ALASKA ADJUSTERS EXAMINATION

THE FOLLOWING NOTEBOOK IS NOT MEANT TO BE ALL INCLUSIVE; BUT IS PROVIDED AS AN OVERVIEW OF MATERIALS COVERED ON LIMITED LINES ADJUSTERS EXAMINATION (AS OF MAY 1, 1993).

Additional references are available in Northern Adjusters, Inc. library, would recommend a review of Property & Casualty manuals, Alaska Workers' Compensation Act, Liability Basics, and other basic insurance texts.

For the May 1, 1993 examination, the content outline provided was a reliable representation of questions presented.

OUTLINE

Alaska Reinsurance Intermediary Broker Test Content Outline

Section	Sub-section	Topic	Reference	No. of Test Questions
A.		Alaska laws, rules, and regulations pertaining to Reinsurance Intermediary Brokers	21.27.010–.900	
	1.	RIB qualifications	21.27.020, 21.27.670	
	2.	Trainee RIB	21.27.680	
	3.	Operating requirements for RIB	21.27.690	
	4.	RIB records	21.27.700	

Alaska Reinsurance Intermediary Manager Test Content Outline

Section	Sub-section	Topic	Reference	No. of Test Questions
A.		Alaska laws, rules, and regulations pertaining to Reinsurance Intermediary Managers	21.27.010–.900	
	1.	RIM qualifications	21.27.020; 21.27.730	
	2.	Appointment of an RIM	21.27.100	
	3.	Trainee RIM	21.27.740	
	4.	Operating requirements for RIM	21.27.750	

NAIC's own Adj. Exam manual.

Alaska Adjuster Test Content Outline

good from 12/92

Topic	Reference	No. of Possible Questions on Test
Alaska Unfair Claims Settlement Acts or Practices Regulations - Purpose, Scope & Standards	Order 89-1 & 3 AAC-26.010	3
Alaska Unfair Claims Settlement Acts or Practices Regulations – Application to Claims Handling and Definition of Terms.	3 AAC-26.010 through 300	33
Statutory Retention of Claim Records	AS 21.27.350(c)	1
Required Statutory and Regulatory Method of Payment of Claims	3 AAC 26.07(d) & AS 21.89.030.	1
Statutorily required minimum liability limits for automobile insurance	AS 21.89.020 & AS 28.22.111(d)	2
Valuation of settlements: Definition and application of terms such as: "Indemnification," subrogation," "Actual Cash Value" "Replacement Cost Value," & the function of "loss reserves".	Property and Liability Insurance Principals (INS) 21 & 22), 1st & 2nd Ed., by The Insurance Institute of America, & also commonly found in most insurance claims references and texts.	5
Application of "comparative negligence" in liability claims; Definition of insurance terms, "special, general and punitive damages"	Property and Liability Insurance Principals (INS 21 & 22), 1st & 2nd Ed., by The Insurance Institute of America, & commonly found in most insurance claims references and texts.	3
Definition and application of common insurance terms, such as; "loss payee, named insured, claim, warranty, claimant, tortfeasor, tort, estoppel, waiver, reservation of rights" and others.	A.I.C. text 34, & 36 1990; Merritts Glossary of Insurance Terms, 4th Ed., Black's Law Dictionary, 5th Edition; Also, commonly found in most insurance claims references and texts.	11
Fidicuary relationship between the insured, the adjuster and the insurer.	Adjustment of Property Loss 4th Ed., Thomas & Reed	1
Duty to defend in the personal or family auto policy; Elements of the personal or family auto policy; Coverage applications of the family auto policy	Liability Claim and Concepts Practices, Prahl and Utrata, & the Family Auto Policy form	5
The necessary elements of a properly executed reservation of rights or non-waiver agreement.	Liability Claim and Concepts Practices, Prahl and Utrata, Also, commonly found in most insurance claims references and texts.	1
Coverages of the Homeowner's Policy.	Property and Liability Insurance Principals (INS 22), 2nd Ed., Insurance Institute of America, & commonly found in most insurance claims references and texts.	2

AS23. (Workers Comp)? → esp. AS 23.30

Topic	Reference	No. of Possible Questions on Test
Statutory requirements of handling workers' compensation claims, including specific terms and procedures contained in the Alaska Workers' Compensation Act.	The Alaska Workers Compensation Act, AS 23.30	
Standard Exclusions of the Commercial Auto Liability Policy COEPLIN 0 Comm Auto	ISO Commercial Auto Policy, or; FC&S Bulletin Casualty & Surety, Auto, January, 1991, published by National Underwriter Co.	1
Coverages, terms, standard exclusions and concepts contained in the Commercial General Liability Policy (CGL) form CGL WOEP:100	1990 Insurance Services Offices CGL coverage form; or, FC&S Bulletin Casualty & Surety, Public Liability, March, 1990, published by National Underwriter Co.	6
Examples of a professional liability risk; Common reasons for policy recision; Legal term describing the role of geographical location in determining applicable jurisdiction of tort law; The elements of "negligence".	Pictorial/V-Marc, "General Liability Coverages" & "Legal Concepts & Doctrines"; Black's Law Dictionary, Fifth Edition; Also commonly found in most insurance claims references and texts.	4
Common exclusions of an Inland Marine Policy and a Boiler and Machinery Policy.	Boiler & Machinery policy; Inland Marine policy, ISO.	2

Ocean Marine Coverage

SUMMARY

FIDUCIARY RELATIONSHIP BETWEEN INSURED, ADJUSTER & INSURER

- relationship of trust
- fiduciary agent cannot commingle acct money except under certain conditions

DUTY TO DEFEND IN PERSONAL OR FAMILY AUTO POLICY

- elements of personal or family auto policy
- coverage applications of family auto policy

Basic Coverages:
1. Liability
2. Medical payments
3. Uninsured motorist coverage
4. Coverage for damage to your auto

Obligation to: Defend any suit alleging such bodily injury or property damage and seeking damages payable under terms of the policy - if controversy w/in scope of policy-duty to defend

4 Elements of Policy = D.I.C.E.
Declarations
Insuring agreement
Conditions
Exclusions

NECESSARY ELEMENTS OF A PROPERLY EXECUTED RESERVATION OF RIGHTS OR NON-WAIVER AGREEMENT

Notice of other party position

2. Timely notice

3. Must adequately and fairly inform insured of insurer's position and right to retain counsel-clearly define coverage question.

COVERAGE OF HOMEOWNER'S POLICY
(d.a.p.a.p.o.)

Coverage:
A. Dwelling
B. Appurtenant structures
C. Personal property
D. Additional expenses/loss of use
E. Personal liability
F. Others med pay

STATUTORY REQUIREMENTS OF WORK COMP. CLAIMS
Refer to AWCB Act

1. Disability benefits

2. Medical benefits

3. Survivor benefits

4. Rehabilitation benefits

STANDARD EXCLUSIONS OF THE COMMERCIAL AUTO LIABILITY POLICY
(C.O.E.P.I.Mo.O.)

1. Contracts - liability assumed under contract or agreement except - insured's contracts.

2. Owned Property - Damage to property owned by, transported by, or in care, custody, or control of insured.

3. Employee's injuries.

4. Pollution liability

5. Intended injuries or expected.

6. Mobile equipment operation liability.

7. "Operations completed" liability

COMMERCIAL GENERAL LIABILITY POLICY - COVERAGES, TERMS, STANDARD, EXCLUSIONS, CONCEPTS

Coverage A	Bodily injury and property damage
Coverage B	Personal and advertising injury liability
Coverage C	Medical payments

Occurrence: An accident including repeated exposure to conditions; occurrence during policy period.

"Claims Made": Coverage for claims made during policy period.

Exclusions (w.o.e.p.i.l.o.o.)
War
Owned property-auto, aircraft, or watercraft accidents
Employees/work related activities
Pollution liability
Intentional acts
Liquor shop liability
Operations completed-cost to recall defective parts

Others property in insured's care

EXAMPLES OF A PROFESSIONAL LIABILITY RISK: Common reasons for policy recision; legal term of geographical location in determining applicable jurisdiction of Tort Law; elements of negligence.

Professional Liability: Liability arising out of rendering or failure to render services of a professional nature, i.e., physicians, surgeons, dentists, and lawyers.

- Malpractice insurance
- Errors & Omissions

2 kinds of legal duty to clients:

1. Perform services hired for,
2. Perform services w/appropriate standard of conduct

lex loci:	law of the place
lex loci delecti:	law of place where wrong took place
lex fori:	law of the forum; procedural law of court where action is brought.

Negligence: Failure to use care required to protect others from unreasonable chance of harm.

1. Must be a duty owed
2. duty must have been violated
3. actual damages must have been sustained
4. must have been a direct causal relationship between breach of duty and damage.

Comparative
Contributory

Cancellation of policies
- only if in effect less than 60 days; except for:

*non-payment of premium - 20 days notice required

*suspension or revocation of insured's drive's license or registration - 10 day notice required

*Non-renewal after policy in effect 1 yr - 30 day notice required

*hazardous action - 10 day notice

COMMON EXCLUSIONS OF AN INLAND MARINE POLICY AND A BOILER MACHINERY POLICY

Boiler and Machinery Exclusions:

- o war
- o ordinance or law which increases loss
- o nuclear hazard
- o others: fire, explosion, accident while testing, accident from earth moving, lack of power, loss of use, indirect result of accident.

Inland Marine insurance covers: imports, exports, domestic shipments, bridges, tunnels, and other transport and communication modes.

Covers transported items with direct connection w/transport.

Also know -- ocean marine coverage - 1 question on test about it.

ALASKA UNFAIR CLAIMS SETTLEMENT ACTS OR PRACTICES REGULATIONS
(Purpose, Scope and Standards)

Purpose: To determine minimum standards for claim settlements and practices.

Scope: Apply to all persons transacting business of insurance who participate in investigation, adjusting, negotiation, or settlement of a claim under all types of insurance.

APPLICATION TO CLAIMS HANDLING AND DEFINITION OF TERMS

I. Handing first party claims

- o Within ten days after receipt of notification of claim - give written acknowledgement to first party claimant of adjuster, pone number, firm and file number.
- o Within 15 days - reply to all other communications from

first party claimant.

- Upon receipt of claim - provide forms, instructions, and assistance.

II. Handling Third Party Claims

- Within ten days - acknowledge
- Within 15 days - reply
- Provide necessary info.
- Within ten days - acknowledge to insured of adjuster

III. Standards for Prompt Investigation of Claims

- Within 30 days - undertake and complete investigation *specify in writing any need for additional time

IV. Disclosure and Representation of Coverage Provisions

A. Disclosure information on benefits

- Cannot deny claim on grounds of not providing information without written proof of demand.
- May not require information from claimant in writing within time limit.
- Cannot request First Party Claimant to C&R beyond subject matter.
- Cannot issue check/payment in partial settlement of loss which releases insured from other liability.

V. Standards for Prompt, Fair, and Equitable Settlements

A. First Party Claims

1. Advise claimant of acceptance/denial within 15 days.
2. Within 30 days - pay all portions not in dispute
3. Not fail to settle on basis of responsibility for payment must be assumed by others.
   - No time limit to settle
   - Shall pay judgement or settlement on claim

Additional Standards for Prompt, Fair, and Equitable Settlements of Motor Vehicle Claims

A. Apply one of the following methods:

1. Offer comparable and available replacement motor vehicle

2. Cash settlement - actual cash for comparable motor vehicle

B. Provide reasonable written explanation of valuation of damages.

C. Include First Party Claimant deductible.

Additional Standards for Prompt, Fair and Equitable Settlements of Third Party MV claims

A. Provide written explanation of value of damages - may not recommend claimant claim under own coverage to delay or avoid paying claim.

1. Claimant may not be required to travel unreasonably

2. Any estimate must be fair and appropriate

3. Itemize each deduction and explain

4. Guarantee repairs if choosing a specific facility

5. For totalled care-can't reduce salvage by cleaning amount.

VIII. Additional Standards for Prompt, Fair and Equitable Settlements of Property Claims

A. Apply one of the following methods:

1. Offer specific comparable and avail replacement property

2. Cash settlement based on actual cash of comparable property

a. Provide written explanation of valuation
b. Include First Party deductible

B. Third Party Claims (Refer to auto 3rd party)

IX. Additional Standards for Prompt, Fair and Equitable Settlements of workers' compensation claims

A. May not require claimant to travel unreasonably for medical care

B. Provide information

C. Promptly make payment/issue denials

X. Standards for Disability Claims

A. Maintain or use statistically credible profile of medical care updated at least every six months

B. Provide complete explanation of payments - document in claim

STATUTORY RETENTION OF CLAIM RECORDS

Five years from date of closure.

REQUIRED STATUTORY AND REGULATORY METHOD OF PAYMENT OF CLAIMS
(As per Unfair Claims Settlement Act)

With negotiable check payable in cash to payee upon presentation to a bank located in Alaska.

STATUTORY REQUIRED MINIMUM LIABILITY LIMITS FOR AUTO INSURANCE

Mandatory minimum:	BI/person	$ 50,000
	BI/accident	$100,000
	Prop Damage	$ 25,000

VALUATION OF SETTLEMENTS

Indemnification: The insured is restored to approximate financial condition occupied before loss.

Subrogation: Right to take legal action against 3rd party responsible for a loss for a claim which has been paid.

Actual Cash Value: Cost of replacing damaged or destroyed property with comparable new property, minus depreciation and obsolescence.

Replace Cost Value: Cost to replace damaged or destroyed property with one of like kind and quality.

Loss Reserves: Provision for known claims due but not paid, not yet due and incurred but not reported.

APPLICATION OF COMPARATIVE NEGLIGENCE

Comparative Negligence: Each party's negligence is based on party's contribution to accident.

Liability, civil damages warded

1. Special damages: reimburse out of pocket expenses (medicals time, loss, and property damage)

2. General damages: "Pain and Suffering"

3. Punitive damages: Damages reimbursed due to gross negligence by defendant.

COMMON INSURANCE TERMS

Loss Payee: Payable to for losses.

Named insured: Person, business, or organization specified as insured in property or liability policy.

Claim: The right, real, or alleged, to recover for a loss which may come within an insured's policy contract.

Warranty: Pledge by an insured that a particular condition exists or not.

Claimant: One who submits a claim.

Tortfeasor: Person who commits a tort, wrongful act causing injury or damage.

Tort: A civil wrong which a court provide a remedy in form of suit for damage; negligent acts or omissions.

Estoppel: Stop or bar, one party makes a statement which another relies upon, thereby preventing first party from denying validity of statement.

Waiver: Relinquishment of a legal right to act.

Reservation of rights: Accepting a claim with qualifications.

UNFAIR CLAIMS ACT

know inside s ord

3 AAC 25.900. DEFINITIONS. In 3 AAC 25.010 — 3 AAC 25.900

(1) "director" means the director of the division of insurance;

(2) "division" means the division of insurance in the Department of Commerce and Economic Development;

(3) "excess workers' compensation" means that coverage insuring a qualified self-insured employer's obligations to provide workers' compensation benefits to its employees in excess of a primary self-insured amount. (Eff. 8/28/91, Register 119)

Authority: AS 21.06.090 AS 21.34.250

CHAPTER 26. TRADE PRACTICES

Article

Article 1. Unfair Claims Settlement Acts or Practices

Section

3 AAC 26.010. PURPOSE. (a) The purpose of 3 AAC 26.010 — 3 AAC 26.300 is to define minimum standards for claim settlement acts and practices.

(b) Violation of a standard is an unfair or deceptive act and is prohibited.

(c) Violation of a standard with such frequency as to indicate a general business practice is an unfair or deceptive practice and is prohibited.

(d) Violation of a standard by a person who knew or should have known an act or practice violated the standard is subject to an additional penalty under AS 21.36.320(e). (Eff. 5/6/89, Register 110)

Authority: AS 21.06.090 AS 21.36.010 AS 21.36.125 AS 21.36.150 AS 21.36.320 AS 21.36.350

3 AAC 26.020. SCOPE. 3 AAC 26.010 — 3 AAC 26.300 apply to all persons transacting a business of insurance who participate in the investigation, adjustment, negotiation, or settlement of a claim under all types of insurance. (Eff. 5/6/89, Register 110)

Authority: AS 21.03.010 AS 21.06.090 AS 21.33.011 AS 21.36.020 AS 21.36.125 AS 21.36.350 AS 21.75.310 AS 21.76.020 AS 21.84.050 AS 21.87.020 AS 21.88.010

3 AAC 26.030. FILE AND RECORD DOCUMENTATION. Any person transacting a business of insurance who participates in the investigation, adjustment, negotiation, or settlement of a claim under any type of insurance must document each action taken on a claim. The documentation must contain all notes, work papers, documents and similar material. The documentation must be in sufficient detail that relevant events, the dates of those events, and all persons participating in those events can be identified. The documentation may include legible copies of originals and may be stored in the form of microfilm or electronic media. The documentation is subject to examination and copying by the director or persons acting on the director's behalf. (Eff. 5/6/89, Register 110)

Authority: AS 21.06.090 AS 21.06.120 AS 21.06.130 AS 21.36.090 AS 21.36.125 AS 21.36.350 AS 21.36.410

3 AAC 26.040. REQUIRED CLAIM COMMUNICATION. (a) Any person transacting a business of insurance who participates in the investigation, adjustment, negotiation, or settlement of a first-party claim must:

(1) within 10 working days after receipt of notification of a claim, give written acknowledgement to the first-party claimant identifying the person handling the claim, including the person's name, address, telephone number, the firm name, and the file number; payment of the claim within 10 working days after notification is satisfactory acknowledgement; provision of necessary claim forms, written instructions, and assistance as required in (3) of this subsection is satisfactory acknowledgement; notification of a claim to an agent constitutes notification to the principal;

(2) within 15 working days after receipt, make an appropriate reply to all other communications from a first-party claimant which reasonably indicates that a response is expected; receipt of a communication by an agent constitutes receipt by the principal;

(3) upon receipt of notification of a claim, promptly provide necessary claim forms, instructions, and assistance so that the first-

party claimant is able to comply with legal, policy, or contract provisions and other reasonable requirements.

(b) Any person transacting a business of insurance who participates in the investigations, adjustment, negotiation, or settlement of a third-party claim must:

(1) within 10 working days after notification of the claim from a third-party claimant, give written acknowledgement to the third-party claimant, identifying the person handling the claim, including the person's name, address, phone number, the firm name, and the file number; payment of the claim within 10 working days after notification is satisfactory acknowledgement; provision of necessary claim forms, written instructions, and assistance as required in (3) of this subsection is satisfactory acknowledgement; notification of a claim to an agent constitutes notification to the principal;

(2) within 15 working days after receipt, make an appropriate reply to all other communications from a third-party claimant which reasonably indicates that a response is expected; receipt of a communication by an agent constitutes receipt by the principal;

(3) upon receipt of notification of a claim from a third-party, promptly provide necessary claim forms, instructions and assistance that is reasonable so that the third-party claimant is able to comply with any reasonable requirement;

(4) within 10 working days after notification of a claim received from or on behalf of an insured, give written acknowledgement to the insured, identifying the person handling the claim, including the person's name, mailing address, telephone number, the firm name, and the file number; notification of a claim to an agent constitutes notification to the principal.

(c) If notification of a claim is received in the form of a suit, a demand for arbitration, application for adjudication, or other pleading, any person transacting a business of insurance who participates in the investigation, adjustment, negotiation, or settlement of a claim shall comply with the rules of that particular forum rather than this section only so long as the claim is pending in that forum. (Eff. 5/6/89, Register 110)

Authority: AS 21.06.090 AS 21.36.125 AS 21.36.350

3 AAC 26.050. STANDARDS FOR PROMPT INVESTIGATION OF CLAIMS. (a) Any person transacting a business of insurance who participates in the investigation, adjustment, negotiation, or settlement of a claim shall promptly undertake the investigation of a claim after notification of the claim is received, and shall complete the investigation within 30 working days, unless the investigation cannot reasonably be completed using due diligence.

(b) Unless the notification of a claim is in the form of a suit, demand for arbitration, application for adjudication, or other pleading, or the claim becomes the subject of such litigation within 30 working days, the person transacting the business of insurance shall give written notification to the claimant that specifically states the need and reasons for additional investigative time and also specifies the additional time required to complete the investigation. That notification shall be given no later than the 30th working day after notification of the claim is first received. (Eff. 5/6/89, Register 110)

Authority: AS 21.06.090 AS 21.36.125 AS 21.36.350

3 AAC 26.060. DISCLOSURE AND REPRESENTATION OF COVERAGE PROVISIONS. Any person transacting a business of insurance who participates in the investigation, adjustment, negotiation, or settlement of a claim:

(1) shall fully disclose to a first-party claimant all relevant benefits and other provisions of coverage under which a claim may be covered;

(2) may not deny a claim on the ground that the first-party claimant failed to exhibit the property without written proof of demand and the unwarranted delay or refusal by the first-party claimant to do so;

(3) may not, except where there is a time limit specified in the coverage document, make statements, written or otherwise, requiring a first-party claimant to give written notice of loss, statement of claim, proof of loss, or similar affidavit within a specified time limit;

(4) may not request a first-party claimant to agree to a compromise or enter into a release that extends beyond the subject matter that gives rise to the claim payment; and

(5) may not issue a check, draft, warrant or other claim payment in partial settlement of a loss or claim under a specified coverage, which contains language that releases or compromises the issuer or its principal from any other liability. (Eff. 5/6/89, Register 110)

Authority: AS 21.06.090 AS 21.36.125 AS 21.36.350

3 AAC 26.070. STANDARDS FOR PROMPT, FAIR, AND EQUITABLE SETTLEMENTS. (a) Any person transacting a business of insurance who participates in the investigation, adjustment, negotiation, or settlement of a first-party claim:

(1) shall advise a first-party claimant in writing of the acceptance or denial of the claim within 15 working days after receipt of a properly executed statement of claim, proof of loss, or other ac

ceptable evidence of loss unless another time limit is specified in the insurance policy, insurance contract, or other coverage document; payment of the claim within this time limit constitutes written acceptance; a written denial of the claim must state the specific provisions, conditions, exclusions, and facts upon which the denial is based; if additional time is needed to determine whether the claim should be accepted or denied, written notification giving the reasons that more time is needed shall be given to the first-party claimant within the deadline. While the investigation remains incomplete, additional written notification shall be provided 45 working days from the initial notification, and no more than every 45 working days thereafter giving the reasons that additional time is necessary to complete the investigation; if there is a reasonable basis supported by specific information for suspecting that a first-party claimant has fraudulently caused or wrongfully contributed to the loss, and the basis is documented in the claim file, this reason need not be included in the written request for additional time to complete the investigation or the written denial; however, within a reasonable time for completion of the investigation and after receipt of a properly executed statement of claim, proof of loss, or other acceptable evidence of loss, the first-party claimant shall be advised in writing of the acceptance or denial of the claim;

(2) shall, within 30 working days after receipt of a properly executed statement of claim, proof of loss, or other acceptable evidence of loss, pay those portions of the claim not in dispute;

(3) may not fail to settle first-party claims on the basis that responsibility for payment must be assumed by others, except as may be expressly provided by provisions of the insurance policy, insurance contract, or other coverage document.

(b) A person transacting a business of insurance who participates in the investigation, adjustment, negotiation, or settlement of a third-party claim may not make any statement that indicates that the rights of a third-party claimant may be impaired if a form, compromise, release, or similar document is not completed within a given period of time, unless the statement is given for the purpose of notifying the third-party claimant of an applicable statute of limitation.

(c) Any person transacting a business of insurance who participates in the investigation, adjustment, negotiation, or settlement of a claim may not continue negotiations for settlement of the claim directly with any claimant who is neither an attorney nor represented by an attorney to a time when the claimant's rights might be affected by a statute of limitation, coverage provision, or other time limit, unless written notice is given to the claimant clearly stating the time limit that might be expiring and its effect upon the claim; such a

written notice shall be given at least 60 calendar days before the date on which the time limit might expire.

(d) Any person transacting a business of insurance who participates in the investigation, adjustment, negotiation, or settlement of a claim shall pay a judgment or settlement of the claim (including advances, partial settlements, or similar payments) with a negotiable check payable in cash to the payee upon presentation to a bank located in Alaska. If the check is not drawn upon a bank having a physical location in Alaska, it must be payable in cash upon presentation to at least one bank having a physical location in Alaska. (Eff. 5/6/89, Register 110)

Authority: AS 21.06.090 AS 21.36.350 AS 21.89.030
AS 21.36.125

3 AAC 26.080. ADDITIONAL STANDARDS FOR PROMPT, FAIR, AND EQUITABLE SETTLEMENTS OF MOTOR VEHICLE CLAIMS. (a) Any person transacting a business of insurance who participates in the investigation, adjustment, negotiation, or settlement of a first-party motor vehicle claim must:

(1) apply one of the following settlement methods if coverage provides for the adjustment of a motor vehicle total loss on the basis of actual cash value or replacement with a vehicle of like kind and quality:

(A) offer a comparable and available replacement motor vehicle, with all applicable taxes, license fees, destination or delivery charges, and other fees incident to transfer of ownership of the motor vehicle paid, at no cost to the first-party claimant other than the deductible amount, if any, as stated in the coverage; the offer of a replacement motor vehicle shall be made in writing if rejected by the first-party claimant; or

(B) make a cash settlement based upon the actual cost to purchase a comparable motor vehicle, including all applicable taxes, license fees, destination or delivery charges, and other fees incident to transfer of ownership, less the deductible amount, if any, as stated in the coverage; the cost shall be determined by:

(i) the cost of a comparable motor vehicle in the local market area to the claimant, if that motor vehicle is available in that area; or

(ii) the average of two or more cost quotations obtained for a comparable motor vehicle from two or more qualified dealers located within the local market area, if a comparable motor vehicle is not available in that area; or

(iii) a basis that is allowable under the coverage but deviates from the rules set out in (i) and (ii) of this subparagraph, if the

deviation is supported by documentation in the claim file which gives the particulars of the condition of the motor vehicles involved; any deduction from the cost of a comparable motor vehicle, including deduction for salvage value, must be a fair and appropriate amount; the basis for the deduction shall be fully explained to the claimant;

(2) provide to a first-party claimant a reasonable written explanation of the valuation of damages to the motor vehicle;

(3) include the first-party claimant's deductible, if any, in a subrogation demand unless the first-party claimant requests that it not be included or unless the deductible has been otherwise recovered by the first-party claimant; no deduction for expense may be made from any deductible recovered unless an outside attorney or other outside expert witnesses have been retained and any deduction is no more than a pro rata share of their cost less any attorney fees and costs recovered; any recovery of prejudgement or postjudgement interest shall be shared pro rata.

(b) Any person transacting a business of insurance who participates in the investigation, adjustment, negotiation, or settlement of a third-party motor vehicle claim:

(1) shall provide a third-party claimant a reasonable written explanation of the valuation of damages to a motor vehicle which is the basis of any settlement offer;

(2) may not recommend that a third-party claimant make a claim under the claimant's own coverage in order to delay or avoid paying a claim where liability and damages are reasonably clear.

(c) A claimant may not be required to travel unreasonably either to inspect a replacement motor vehicle, obtain a repair estimate, or have the motor vehicle repaired at a specific facility.

(d) Any estimate or appraisal of the cost of repair of a motor vehicle must be in a fair and appropriate amount that the claimant may reasonably be expected to be charged for repairs at one or more conveniently located repair facilities.

(e) If the amount claimed as damage to the motor vehicle is reduced on the basis of betterment or depreciation, the person adjusting or settling the claim shall itemize each deduction and explain the basis for each reduction in writing to the claimant.

(f) If a person adjusting or settling a claim elects to have repaired a claimant's motor vehicle and chooses a specific facility for the repairs, that person shall guarantee the repairs and cause the damaged motor vehicle to be restored to its condition before the loss, at no additional cost to the claimant, and cause the repairs to be completed within a reasonable time.

(g) If the claimant's motor vehicle is determined to be economically unrepairable and, therefore, a total loss, the person adjusting

or settling the claim may not reduce the salvage value of the vehicle by charges for cleaning. (Eff. 5/6/89, Register 110)

Authority: AS 21.06.090 AS 21.36.125 AS 21.36.350

3 AAC 26.090. ADDITIONAL STANDARDS FOR PROMPT, FAIR, AND EQUITABLE SETTLEMENTS OF PROPERTY CLAIMS. (a) Any person transacting a business of insurance who participates in the investigation, adjustment, negotiation, or settlement of a first-party property claim shall:

(1) apply one of the following settlement methods if coverage provides for the adjustment of a claimant's property loss on the basis of actual cash value or replacement with other property of like kind and quality;

(A) offer specific comparable and available replacement property, with all applicable taxes, charges, and other fees incident to the transfer of ownership of the property at no cost to the claimant other than the deductible amount, if any, as stated in the coverage; the offer of replacement property shall be in writing if rejected by the first-party claimant; or

(B) make a cash settlement based upon the actual cost of comparable property, including all applicable taxes, charges and other fees incident to transfer of ownership, less the deductible amount, if any, as stated in the coverage; the cost shall be determined by:

(i) the cost of comparable property in the local market area to the claimant, if such property is available in that area; or

(ii) the average of two or more cost quotations obtained for comparable property from two or more qualified dealers, suppliers or contractors located within the local market area, if comparable property is not available in that area; or

(iii) settle a loss on a basis that deviates from the rules set out in (i) and (ii) of this subparagraph, if the deviation is supported by documentation in the claim file which gives the particulars of the condition of the property involved; the valuation, including salvage value of the property lost, if any, must be in an adequate and appropriate amount; the basis for settlement shall be fully explained to the claimant;

(2) provide to a first-party claimant a reasonable written explanation of the valuation of the damages to the property;

(3) include the first-party claimant's deductible, if any, in a subrogation demand unless the first-party claimant requests that it not be included or unless the deductible has been otherwise recovered by the first-party claimant; no deduction for expense may be made from any deductible recovered unless an outside attorney or

other outside expert witnesses have been retained and deduction may be for no more than a pro rata share of their cost less attorney fees and costs recovered; any recovery of prejudgement or post-judgement interest shall be shared pro rata.

(b) Any person transacting the business of insurance who participates in the investigation, adjustment, negotiation, or settlement of a third-party property claim:

(1) shall provide to a third-party claimant a reasonable written explanation of the valuation of damages to property which is the basis of any settlement offer;

(2) may not recommend that a third-party claimant make a claim under the claimant's own coverage in order to delay or avoid paying a claim where liability and damages are reasonably clear.

(c) Any person settling or adjusting a property claim may not require a claimant to travel unreasonably either to inspect replacement property, obtain a repair estimate, or have the property repaired at a specific facility.

(d) Any estimate of the costs of the repair of the property must be a fair and appropriate amount for which the damage can be reasonably expected to be repaired at one or more conveniently located repair facilities, dealers, or contractors.

(e) Any person who reduces the amount claimed as damage to property on the basis of betterment or depreciation shall itemize each deduction. The basis for the reduction shall be documented in the claim file.

(f) If a person adjusting or settling a claim elects to have repaired a claimant's property and chooses a specific repair facility, dealer, or contractor, that person shall guarantee the repairs and cause the damaged property to be restored to its condition before the loss, at no additional cost to the claimant, and cause the repairs to be completed within a reasonable period of time. (Eff. 5/6/89, Register 110)

Authority: AS 21.06.090 AS 21.36.125 AS 21.36.350

3. AAC 26.100. ADDITIONAL STANDARDS FOR PROMPT, FAIR, AND EQUITABLE SETTLEMENTS OF WORKERS' COMPENSATION CLAIMS. Any person transacting a business of insurance who participates in the investigation, adjustment, negotiation, or settlement of a workers' compensation claim:

(1) may not require a claimant to travel unreasonably for medical care, rehabilitation services, or any other purpose;

(2) shall provide necessary claim forms, written instructions, and assistance that is reasonable so that any claimant not represented by an attorney is able to comply with the law and reasonable claims handling requirements;

(3) shall promptly make all payments or denials of payments as required by statute or regulation. (Eff. 5/6/89, Register 110)

Authority: AS 21.06.090 AS 21.36.125 AS 21.36.350

3 AAC 26.110. ADDITIONAL STANDARDS FOR PROMPT, FAIR, AND EQUITABLE SETTLEMENTS OF DISABILITY CLAIMS. (a) If a disability insurance policy or a subscriber contract provides for payment of a claim on the basis of services provided by a medical care provider using a usual, customary and reasonable, or prevailing charge basis, a person transacting a business of insurance who participates in the investigation, adjustment, negotiation, or settlement of a claim must:

(1) maintain or use a statistically credible profile of medical care providers' charges on which to base payment of claims, which is updated at least every six months and contains charges for services performed not more than one year before the date of the most recent profile; the profile must contain charges for each geographical area in which a claimant might receive treatment; if the profile does not contain a statistically credible data base for a particular medical care service in a certain geographical area, the insurer may include in the profile a sufficient number of charges for that service from another geographical area so that a reliable basis is established; however, the final basis for payment shall be adjusted to reflect the general cost differences between the geographical area where the service was performed and the other geographical areas used in establishing the statistically credible profile; the adjustment may be based on the Consumer Price Index, the medical care component of the Consumer Price Index, or another reasonable basis stated in writing; the written explanation provided to a claimant must include a complete explanation of these adjustments;

(2) provide to the claimant, in writing, a complete explanation of the basis of payments and document the explanation in the claim file; if the basis for payment is less than the actual charge made by the medical care provider, the explanation to the claimant must state with specificity the reason for the amount not paid.

(b) This section does not apply to workers' compensation claims. (Eff. 5/6/89, Register 110)

Authority: AS 21.06.090 AS 21.36.125 AS 21.36.350

3 AAC 26.300. DEFINITIONS. In this chapter,

(1) "claim" means notice that an event, act or omission has occurred which may result in injury or damage for which an insured may be legally obligated to pay;

(2) "claimant" means a first-party claimant, a third-party claimant, or both, and includes the claimant's legal representative and includes a member of the claimant's immediate family if authorized by the claimant;

(3) "Consumer Price Index" means the data published annually in the Detailed Report by the United States Department of Labor, Bureau of Labor Statistics;

(4) "destination or delivery charges" means the charges for shipping a motor vehicle to a primary residence of the claimant or to where the motor vehicle is primarily operated;

(5) "first-party claimant" means a person asserting a right to payment under his or her own coverage;

(6) "frequency as to indicate a general business practice" means violation of any one standard committed on one or more percent of claims handled within a 12-month period, or the repeated violation of a single standard without reasonable explanation;

(7) "local market area" means the geographical area, in the closest proximity to the claimant's residence, in which two or more qualified dealers are located;

(8) "outside attorney" means an attorney who is in private practice and not an employee of a person transacting a business of insurance under AS 21;

(9) "person" means an individual, corporation, association, partnership, or other legal entity;

(10) "third-party claimant" means any person asserting a claim against any other person;

(11) "usual, customary, and reasonable, or prevailing charge basis" means that payment basis for a disability insurance claim where the reasonable and prevailing charge for a medical care procedure, service, or supply item is determined by the lowest of the following amounts:

(A) the billed amount of the medical care provider's actual charges;

(B) the charge usually made by that provider for performing that procedure; or

(C) the customary charge based on a profile of charges made for the same medical procedure, service, or supply item in the same geographical area by other providers that have performed the same procedure or service or have provided the same supply item;

(12) "working days" means all calendar days except Saturdays, Sundays, all official federal holidays, and all official Alaska holidays. (Eff. 5/6/89, Register 110)

Authority: AS 21.06.090 AS 21.36.125 AS 21.36.350

or of losses arising out of a catastrophe common to all such losses. (§ 1 ch 120 SLA 1966; am § 31 ch 51 SLA 1990)

Effect of amendments. — The 1990 amendment, effective January 1, 1991, in subsection (a), inserted "or general agent" in two places, substituted "appointed" for "licensed as agent," and made a grammatical change.

Sec. 21.27.330. Place of business. A licensed agent, general agent, broker, and adjuster, other than those licensed for life or disability insurances or annuities only, shall have and maintain in this state, or if a nonresident agent or nonresident broker, in the state of domicile, a place of business accessible to the public where the licensee principally conducts transactions under the licenses. The address of the place of business must appear on all licenses of the licensee, and the licensee shall promptly notify the director of any change of address. If the licensee maintains more than one place of business in this state, the licensee shall obtain a license or licenses for each additional place, and shall pay an additional license fee for each license. (§ 1 ch 120 SLA 1966; am § 32 ch 51 SLA 1990)

Effect of amendments. — The 1990 amendment, effective January 1, 1991, inserted "general agent" in the first sentence; substituted "licensee" for "agent, broker, or adjuster" in the second sentence; deleted "duplicate of the" and "duplicate" before "license" in two places in the final sentence; and made grammatical changes.

Sec. 21.27.340. Public display of license. (a) The license or licenses of each agent, general agent, broker, and adjuster, other than licenses as to life or disability insurances or annuities only, shall be displayed in a conspicuous place in that part of the place of business that is customarily open to the public.

(b) The license of a solicitor shall be displayed in each place of business of the agent, general agent, or broker by whom the solicitor is employed. (§ 1 ch 120 SLA 1966; am § 33 ch 51 SLA 1990)

Effect of amendments. — The 1990 amendment, effective January 1, 1991, inserted "general agent, broker, and adjustor" and made related grammatical changes in subsection (a) and inserted "general agent" in subsection (b).

Sec. 21.27.350. Records of agents, brokers, adjusters. (a) An agent, general agent, broker, or adjuster shall keep at the address shown on the license a record of all transactions consummated under the license. This record shall be in organized form and must include

(1) if an agent, general agent, or broker,

(A) a record of each insurance contract procured, issued, or countersigned, together with the names of the insurers and insureds, the amount of premium paid or to be paid, and a statement of the subject of the insurance;

OVERVIEW

* Businessowners policy;
* Commercial General Liability (CGL) policy;
* Commercial Crime forms.

G. Nonpayment of Premium

"Nonpayment of premium" means failure of the Named Insured to discharge when due any of his/her obligations in connection with the payment of premium on a policy, or any installment of the premium, whether the premium is payable directly to the insurer or its agent or indirectly under any premium finance plan or extension of credit.

H. Personal Auto Insurance

"Personal auto insurance" means an insurance policy covering risks and exposures of an automobile policy which includes automobile liability coverage, uninsured motorist coverage, automobile medical payments coverage, or automobile physical damage coverage. Under personal auto insurance, the insured vehicles are of the following types only:

* a motor vehicle of the private passenger or station wagon type that is not used as a public or livery conveyance, nor rented to others; or
* any other four-wheeled motor vehicle with a load capacity of 1,500 pounds or less which is not used in the occupation, profession or business of the insured, nor used as a public or livery conveyance nor rented to others.

I. Personal Insurance

"Personal insurance" provides coverage to personal exposure as opposed to commercial endeavors. Examples of personal insurance policies covered in this textbook are:

* Dwelling Property program;
* Homeowners program;
* Personal Auto policy.

J. Renewal

"Renewal" or "to renew" means:

* the issuance and delivery by an insurer of a policy replacing at the end of the policy period a policy previously issued and delivered by the same insurer;
* the issuance and delivery of a certificate or notice extending the term of the policy beyond its policy period or term; or
* the extension of the term of a policy beyond its policy period term under a provision for extending the policy by payment of a continuation premium.

2. Binders

"Binders" are temporary contracts of insurance issued to a prospective insured to substantiate coverage until a permanent contract can be offered or denied.

Binders can be verbal or written. They encompass the insuring agreement, conditions, exclusions and any endorsements attached to the policy requested.

Binders are valid in property and casualty insurance until one of the following occurs:

* issuance of the permanent policy;
* *90 days* from the effective date of coverage have elapsed.

If the policy has not been issued, a binder may be extended or renewed after the 90 days *with the written approval of the insurer.*

This section does not apply to:

* life insurance; or
* disability insurance; and
* annuities.

3. PROPERTY AND AUTOMOBILE CANCELLATION

Alaska law provides detailed provisions concerning the cancellation of the following contracts:

* property;
* automobile.

We shall discuss these in detail.

A. Property Contracts

After a property contract has been in effect *for sixty (60) days* or more, it cannot be cancelled, except for one of the following reasons:

* nonpayment of premiums;
* conviction of the insured of a crime having as one of its necessary elements an act increasing a hazard insured against;
* discovery of fraud or material misrepresentation made by the insured or his/her representative in obtaining the insurance or by the insured in pursuing a claim under the policy;
* discovery of a grossly negligent act or omission by the insured that substantially increases the hazard insured against;
* physical changes in the insured property that result in the property becoming uninsurable.

Insurers must give the insured *thirty (30) days' written notice* of cancellation.

Cancellation for *nonpayment of premium* only requires *twenty (20) days' written notice*.

If the cancellation is due to discovery of fraud or material misrepresentation by the insured or conviction of a crime having as one of its necessary elements an act increasing a hazard insured against, *a ten (10) day written notice* of cancellation must be mailed to the insured.

An insurer may not cancel *a business or commercial policy* unless a written notice of cancellation is mailed to the Named Insured and to the agent or broker of record *at least:*

* *sixty (60) days* before the effective date of cancellation;
* *twenty (20) days* for nonpayment of premium;
* *ten (10) days* for discovery of fraud or material misrepresentation made by the insured or the insured's representative in obtaining the insurance or by the insured in pursuing a claim under the policy.

B. Automobile Contracts

An auto policy can be canceled for any reason during the first sixty (60) days after issue.

Once an auto policy has been in effect for 60 days, it can only be cancelled for:

* non-payment of premium;
* fraud or misrepresentation in an insurance application or renewal application;
* conviction of insured of a crime which increases the hazard insured against;

* discovery of insured's gross negligence which increases the hazard insured against;
* physical changes in the insured vehicle making it uninsurable.

Reasons for cancellation must be specified in a notice sent to the insured twenty (20) days prior to the effective date by registered mail. If the reason for cancellation is non-payment of premium, only ten (10) days' notice need be given.

Non-renewal of policies in force less than 12 months is *not* permitted.

Non-renewal requires twenty (20) days' notice without specifying the reason.

No insurer may refuse to issue or renew an auto policy because of the age, sex, race, occupation or principal place of garaging of the Named Insured.

4. CIVIL RULE 82

Under Civil Rule 82, a court in Alaska may award attorney's fees as a matter of course to the prevailing party in litigation. In a case where an insured defendant loses his/her case, Civil Rule 82 can result in the insurer paying the plaintiff's attorney's fees as well as all costs related to the defense of the claim.

In response to this rule, insurers applied to the insurance department for relief. After much deliberation, the insurance department allowed insurers writing auto liability insurance in Alaska to limit the supplementary payments aspect of the policy in the area of legal costs. A limit for attorney's fees was set by regulation. When insurers limit legal defense cost coverage in auto liability policies, they must "clearly disclose to insureds the limitation and the insured's potential liability for attorney's fees where judgment exceeds the liability limits of the policy."

Insurers may provide coverage in excess of that required by the regulation for an additional charge. This additional coverage may be offered to provide the insured protection against substantial additional liability related to the defense of an insurance claim.

5. ALASKA AUTOMOBILE INSURANCE

A. Comparative Negligence

As of 1975, Alaska adopted a comparative negligence law in connection with liability settlements.

Under Alaska's pure version of comparative negligence, a person may recover damages in an accident or occurrence regardless of his/her own negligence.

Comparative negligence differs significantly from contributory negligence. Under the latter, if an individual contributes even slightly to an accident, he/she can recover *no damages*.

B. Compulsory Insurance

Alaska has enacted compulsory insurance and financial responsibility laws on owners and operators of motor vehicles. All registered motor vehicles in Alaska must carry a minimum level of financial security regardless of involvement in an accident.

The limits of compulsory insurance specified are minimum requirements for amounts recoverable for B.I. per person/B.I. per accident/P.D.. per accident as follows: 50/100/25.

C. Financial Responsibility

(1) Definition of Proof

According to the Alaska "Motor Vehicle Safety Responsibility Act," the legislature is concerned over the rising total of motor vehicle accidents and the suffering and loss inflicted by them. The legislature determines that it is a matter of grave concern that motorists be

financially responsible for their negligent acts so that innocent victims of motor vehicle accidents may be recompensed for the injury and financial loss inflicted upon them. The legislature finds and declares that the pubic interest can best be served by the requirements that the operator of a motor vehicle involved in an accident respond for damages and show proof of financial ability to respond for damages in future accidents as a prerequisite to his/her exercise of the privilege of operating a motor vehicle in the state.

The financial responsibility requirements *apply to the driver and owner of a vehicle subject to registration under law of this state* which is involved in any manner in an accident in this state resulting in:

* bodily injury to or death of a person; or
* damage to the property of any one person *exceeding $500.*

Not less than twenty (20) days after receipt of a report of such accident, the department must determine the amount of security which it considers sufficient to satisfy any judgments for damages resulting from the accident which may be recovered against each driver or owner. The determination must not be made with respect to a driver or owner who is exempt from the requirements as to security and suspension.

The department must determine the amount of security deposit required upon the basis of the reports or other information submitted. If a person involved in an accident fails to make a report or submit information indicating the extent of his/her injuries or the damage to his/her property within thirty (30) days after the accident, and the department does not have sufficient information on which to base an evaluation of injuries or damage, then the department may not require a deposit of security for the benefit or protection of the person.

Within thirty (30) days after receipt of report of an accident and upon determining the amount of security to be required, the department must give written notice to every person of the amount of security required to be deposited by him/her and *stating that an order of suspension will be made upon the expiration of ten (10) days after the notice is sent unless within that time security is deposited as required.* No license may be suspended unless the licensee is afforded a hearing by the department at which it is determined that there is a reasonable possibility of a judgment holding him/her liable being rendered.

A peace officer investigating an accident that results in bodily injury to or the death of a person or damage to the property of a person exceeding $500 must inform persons involved in the accident in writing of the requirements of this chapter as they apply to suspension of an operator's license or driving privileges.

Exceptions to Requirement

The requirements as to security and suspension *do not apply to*:

* the driver or owner if the owner had in effect at the time of the accident an automobile liability policy or bond with respect to the vehicle involved in the accident. (A driver is not exempt if at the time of the accident the vehicle was operated without the owner's express or implied permission.);
* the driver who is not the owner if there was in effect at the time of the accident an automobile liability policy or bond with respect to his/her driving of vehicles not owned by him/her;
* a driver or owner whose liability for damages resulting from an accident is, in the judgment of the department, covered by another form of liability insurance policy or bond;
* a person qualifying as a self-insurer or to a person operating a vehicle for a self-insurer;
* the driver or owner of a vehicle involved in an accident in which no injury or damage was caused to the person or property of anyone other than the driver or owner;

* the driver or owner of a vehicle which at the time of the accident was parked, unless the vehicle was parked at a place where parking was prohibited by a law or ordinance;
* the owner of a vehicle if at the time of the accident the vehicle was operated without his/her express or implied permission or was parked by a person operating the vehicle without the permission;
* the owner of a vehicle or the driver of a vehicle operating it with permission if at the time of the accident the vehicle was owned or leased to the United States, this state or a political subdivision of this state or a municipality of the state; or
* the driver or the owner of a vehicle at the time of the accident the vehicle was operated by or under the direction of a police officer who, in the performance of his/her duties, assumed custody of the vehicle.

A policy or bond is not effective unless it is issued by an insurance company or surety company authorized to do business in this state in an amount of at least 50/100/25.

Security/Suspension

If a person fails to deposit security within ten (10) days after the department sends notice, the department must suspend:

* the license of each driver involved in the accident;
* the privilege of operating a vehicle subject to registration if the driver is a nonresident;
* the privilege of the owner to operate or permit the operation within this state of a vehicle subject to registration if the owner is a nonresident.

Release of Liability

A person is relieved from the requirement for deposit of security for the benefit or protection of another person injured or damaged in the accident if he/she is released from liability by the other person.

A covenant not to sue relieves the parties to it as to each other from the security requirements.

If the department evaluates the injuries or damage to a minor in an amount not more than $500, the department may accept, for the purposes of this chapter only, evidence of a release from liability executed by a natural or legal guardian on behalf of the minor without court approval.

A person is relieved from the requirement for deposit of security for a claim for injury or damage arising out of the accident if the person is not liable for the claim.

Payment of Damages

Two or more persons involved in or affected by an accident may at any time enter into a written agreement for the payment of an agreed amount with respect to their claims because of bodily injury, death, or property damage arising from the accident. The agreement may provide for payment in installments. The parties may file a signed copy of the agreement with the department.

If proof of financial responsibility is provided by the written agreement filed with it, the department must not require the deposit of security and must terminate a previous order of suspension. If security was deposited, the department must immediately return the security to the depositor or his/her personal representative.

If there is a default in a payment under the agreement upon notice of default, the department must take action suspending the license of the person in default as is appropriate in case of failure of the person to deposit security when required.

The suspension remains in effect and the license may not be restored until:

* security is deposited as required under this chapter in the amount the department determines; or
* when, following default and suspension, the person in default pays the balance of the agreed amount; or
* one (1) year lapses following the effective date of the suspension and evidence satisfactory to the department is filed with it that during the period no action at law upon the agreement is pending.

The payment of a judgment arising out of an accident releases the judgment debtor from the liability evidenced by the judgment.

Suspension

Unless a suspension is terminated, an order of suspension by the department remains in effect until terminated. No license may be renewed or issued to a person whose license is suspended until:

* proof of financial responsibility for the future is provided; and
* the person deposits or there is deposited on his/her behalf the security required; or
* three (3) years elapse following the date of suspension.

Security

The security deposited is available only for:

* the payment of a settlement agreement covering a claim arising out of the accident upon instruction of the person who made the deposit; or
* the payment of a judgment given against the person required to make the deposit for damages arising out of the accident in an action at law begun no later than one (1) year after the deposit of security for failure to make payments under an agreement to pay.

Every distribution of funds from a security deposit is subject to the limits of the department's evaluation on behalf of a claimant.

Upon the expiration of two (2) years from the date of deposit of security, the security remaining on deposit must be returned to the person who made the deposit or his/her personal representative if an affidavit or other evidence satisfactory to the department is filed with it showing that:

* no action for damages arising out of the accident for which deposit it was made is pending against the person on whose behalf the deposit was made; and
* there does not exist any unpaid judgment against the person in an action.

(2) Persons Required to Show Proof

The operator or owner of a motor vehicle when driven on a highway, vehicular way or area, or on other public property in the state, must have motor vehicle liability insurance or a certificate of self-insurance in effect for the motor vehicle, unless:

* the motor vehicle is being driven or moved on a highway, vehicular way, or a public parking place in the state that is not connected by a land highway or vehicular way to the land-connected state highway system, or a highway or vehicular way with an average daily traffic volume greater than 499; and
* the operator has not been cited within the preceding five (5) years for a traffic law violation with a demerit point value of six (6) or more.

The department must publish annually a list of areas that meet the requirements of this section. This list must be available for public inspection at all division of motor vehicle offices in the state.

The owner or operator of a motor vehicle required to have motor vehicle liability insurance or a certificate of self-insurance must show proof of this insurance when that person is:

* involved in an accident that results in bodily injury to or death of a person, or damage to the property of a person exceeding $500; or
* charged with a traffic law violation with a demerit point value of six (6) or more on the point schedule determined by the department.

Method of Proof

A person involved in an accident is required to prove that a motor vehicle liability insurance or a certificate of self-insurance was in effect must, *within fifteen (15) days of the accident*:

* present a copy of the insurance policy, certificate, bond, or insurance binder that was in effect at the time of the accident to the department for inspection;
* provide the department with written certification from an insurance company, insurance agent, insurance broker or surplus lines broker confirming that a valid motor vehicle liability policy issued in conformity with this chapter was in effect at the time of the accident.

A person charged with a traffic law violation who is required to prove that a motor vehicle liability insurance policy or certificate of self-insurance was in effect must, at the time of that person's initial appearance in court or within fifteen (15) days of the date of the charge of a traffic law violation, whichever is later:

* present a copy of the insurance policy, certificate, bond, or insurance binder that was in effect at the time of the violation to the court for inspection;
* provide the court with written certification from an insurance company, insurance agent, insurance broker, or surplus lines broker confirming that motor vehicle liability insurance was in effect at the time of the violation; or
* advise the court in writing that a certificate of self-insurance was in effect at the time the violation was charged.

The court must immediately report any failure to present proof of insurance to the department.

Proof for the Future

A person whose license is suspended must file proof of financial responsibility for the future before full driving privileges may be restored or limited license privileges are granted.

A filing of proof of financial responsibility is required for a period of three (3) years following expiration of the suspension of license.

Financial Responsibility Summary

In summary, the following are important facts concerning Alaska's financial responsibility requirement:

* Alaska's financial responsibility requirement law requires the establishment of sufficient security to satisfy any judgment from a vehicle operator involved in an accident resulting in bodily injury or property damage.
* Financial responsibility requirements apply to the driver and owner of a vehicle subject to registration (not government vehicles) which is involved in an accident resulting in:
  - bodily injury or death;
  - property damage to any one (1) person exceeding $500.
* Individuals required to be financially responsible will be notified within thirty (30) days of receipt of an accident report that an order of suspension will be made upon the

expiration of ten (10) days.

* The requirements of security and suspension do not apply to individuals maintaining automobile liability insurance and other specified reasons such as:

  legally parked car;

  vehicle operated without the owner's permission;

  certain publicly owned vehicles;

  the operator was employed by the owner of the vehicle;

- the vehicle was operated under the direction of the police.

* If a person fails to deposit security as required, he/she will be subject to:

  driver's license suspension;

  motor vehicle registration suspension.

  Unless a suspension is terminated, an order of suspension by the department remains in effect until terminated and no license may be renewed or issued to a person whose license is suspended until:

  proof of financial responsibility for the future if provided; and

  security is deposited; or

  three (3) years elapse from the date of suspension.

D. Uninsured/Underinsured Motorist

"Uninsured motor vehicle" means a land motor vehicle or trailer of any type:

* to which no bodily injury liability bond or policy applies at the time of the accident;
* to which a bodily injury liability bond or policy applies at the time of the accident, *less than the minimum limit for bodily injury liability specified by the financial responsibility law* of the state in which your covered auto is principally garaged;
* which is a "hit and run" vehicle whose operator or owner cannot be identified;
* to which a bodily injury liability bond or policy applies at the time of the accident, but the bonding or insuring company:

- denies coverage; or
- is or becomes insolvent.

Uninsured motorist coverage is mandatory in Alaska and must be offered in minimum limits of 50/100/25 as well as optional higher limits that equal bodily injury limits.

"Underinsured motor vehicle" means a motor vehicle licensed for highway use with respect to the ownership, operation, maintenance or use of which motor vehicle there is a bodily injury or property damage insurance policy or a bond applicable at the time of the accident *and the amount of insurance or bond*:

* is less than the limit for uninsured and underinsured motorists coverage under the insured's policy;
* has been reduced by payments to persons other than an insured, injured in an accident, to less than the limit for uninsured and underinsured motorists coverage under the insured's policy.

Underinsured motorist coverage must be made available to insureds in Alaska.

The uninsured and underinsured motorists coverage required by law:

* does not apply to bodily injury, sickness, disease, or death of an insured or damage to or destruction of property of an insured until the limits of liability bonds and policies that apply have been used up by payments or judgments or settlements;

* must be a single combined coverage; and
* may be rejected by the insured in writing.

If the insured has rejected uninsured or underinsured coverage, the coverage may not be included in a supplemental, renewal or replacement policy unless the insured subsequently requests uninsured or underinsured coverage in writing.

If both the owner and operator of the insured vehicle are unknown, payment under the uninsured and underinsured motorists coverage may be made only where direct contact between the insured and uninsured or underinsured motor vehicles has occurred. A vehicle that has left the scene of the accident with an insured vehicle is presumed to be uninsured *if the insured person reports the accident to the appropriate authorities within 24 hours*.

The uninsured and underinsured motorists coverage for damage to or destruction of property is *subject to a deductible of $250 in any one accident*, but the insurer may offer a deductible other than $250. This coverage is limited to damage to or destruction of the insured motor vehicle. *It may not include loss of use of such vehicle.*

Maximum Liability of Carrier

The maximum liability of the insurance carrier under the uninsured and underinsured motorist coverage is the difference between the coverage limit of liability and the amount paid to the insured by or on behalf of the uninsured and underinsured motorists.

Amounts payable under the uninsured motorists and underinsured motorists coverage may be reduced by:

* amounts paid or to be paid under any *workers compensation* law;
* amounts paid or payable under any valid and collectible *automobile medical payments* insurance or bodily injury or death liability insurance; and
* amounts paid by or on behalf of the uninsured or underinsured motorist.

Policy Coverage and Priorities

If an insured is entitled to uninsured or underinsured motorists coverage under more than one policy of motor vehicle liability insurance, or under more than one coverage if two or more vehicles are insured under one policy, *the maximum amount an insured may recover may not exceed the highest limit of any one policy or coverage.*

Where multiple policies or coverages apply, payment may be made in the following *order of priority*, subject to the limit of liability for each applicable policy or coverage:

* a policy or coverage covering a motor vehicle occupied by the injured person at the time of the accident;
* a policy or coverage covering a motor vehicle that came into contact with the insured while a pedestrian; and
* a policy or coverage covering a motor vehicle not involved in the accident with respect to which the injured person is an insured or a Named Insured.

Policy Coverage Exclusions

The uninsured and underinsured motorists coverage does not apply to bodily injury or death or damage to or destruction of property of an insured:

* while occupying a motor vehicle owned by, but not insured by, the Named Insured or the insured's spouse or relative residing in the same household; or
* through being struck by a motor vehicle owned by the Named Insured or the insured's spouse or relative residing in the same household.

E. Automobile Assigned Risk

The Automobile Assigned Risk was created to provide auto insurance for individuals unable to obtain same from the voluntary market.

All insurers writing auto insurance in Alaska must participate in the Automobile Assigned Risk to the same degree as they write auto insurance in the state's voluntary market as compared with other insurers writing auto insurance in the state.

The Assigned Risk Plan affords liability and physical damage coverages. "Physical damage only" insurers need not participate in the Assigned Risk Plan.

Minimum liability limits of 50/100/25 as well as increased limits of 100/300/50 are available.

Agreements may be made among insurers with respect to the equitable apportionment among them of insurance which may be afforded applicants who are in good faith entitled to, but who are unable to procure, the insurance through ordinary methods. The insurers may agree among themselves on the use of reasonable rate modifications for the insurance, the agreements and rate modifications to be subject to the approval of the Director.

6. ALASKA WORKERS COMPENSATION ACT

A. Purpose

The Alaska Workers Compensation Act provides for the reimbursement of work-related medical expenses and lost wages. The law is compulsory: All Alaska employers must comply with the provisions of the law, purchasing insurance or providing self-insurance.

B. Requirements and Coverage

The Alaska Workers Compensation Act and its requirements are:

* compulsory to all private employments in the state, including elected or appointed corporate executive officers;
* compulsory as to state public employments.

The following types of employment are *not covered* by the Workers Compensation Act:

* part-time baby-sitters;
* cleaning persons;
* harvest help or similar transient help;
* entertainers employed on a contractual basis;
* commercial fishermen.

C. Meeting Obligations

Alaska employers can meet their obligations as described in this section in one of two ways:

* self-insurance;
* private insurance;
* Assigned Risk Pool of Alaska.

If employers decide to *self-insure*, they must follow the dictates of the Alaska Workers Compensation Law as to their financial requirements, reporting procedures, etc. Very often, very large companies decide to self-insure to reduce administrative expenses.

Workers Compensation insurance is the most popular form of insurance.

The Workers Compensation Assigned Risk Pool of Alaska was created to provide workers compensation insurance to individual employers unable to obtain same in the voluntary market.

The Pool will be discussed in detail shortly.

In order for a business to self-insure in Alaska, it must obtain a *certificate of authority* from the Department of Labor.

D. An Overview

A "plain English" Workers Compensation and Employers Liability policy was drafted by the National Council on Compensation Insurance and introduced nationwide in 1984.

This policy insures employers against claims for work-related injuries to employees as well as diseases acquired by them that are compensable by law.

The new Workers Compensation Policy consists of the following sections:

* Information page;
* General Section;
* Part One - Workers Compensation Insurance;
* Part Two - Employers Liability Insurance;
* Part Three - Other States Insurance;
* Part Four - Your Duties if Injury Occurs;
* Part Five - Premium;
* Part Six - Conditions.

Let's review the pertinent aspects of each of these sections.

E. Information Page/General Section

The *Information Page* replaces the Declarations page, but essentially provides the same valuable information:

* name, address and description of insured company;
* policy period;
* a list of the states to which the policy applies;
* liability limits per accident, disease and employee;
* endorsements and schedules.

The *General Section* reinforces the Information Page by generally defining:

* the purpose of the policy;
* who is insured;
* the relationship of the individual workers compensation laws to the policy.

Under this section, it is noted that the workers compensation law of any covered state includes amendments to the law that take effect during the policy period. Retroactive law changes are *not* covered.

F. Part One - Workers Compensation Insurance

Part One - Workers Compensation Insurance applies to bodily injury (including resultant death) caused by:

* accident; or
* disease.

Bodily injury by accident must occur during the policy period.

Bodily injury by disease must be caused or aggravated by the "conditions of employment." The employee's last day or last exposure to the conditions causing or aggravating the bodily

injury by disease must occur during the policy period.

Payments are made to employees regardless of fault as long as the injuries are work-related.

Under this coverage, the insurer agrees to pay the *benefits* required of the insured by law. The term "benefits" includes both compensation for lost wages and medical care including:

* medical benefits;
* income benefits;
* death benefits.

Alaska State Workers Compensation laws (which provide guidelines for the administration of the workers compensation benefits) provide *unlimited* medical, hospital, surgical and nursing care for the treatment of work-related injuries or disease. *As a result, 100% of medical bills and rehabilitation bills are paid.*

Income and *death benefits amounts* are mandated by Alaska law as follows:

* *Loss of Income* - 66 2/3%;
* *Death Benefits* - 66 2/3% of gross wages for spouse plus children.

Although medical treatment is compensated immediately, payment of lost wages is subject to a waiting period of *four (4) days* in Alaska. If the disability causing the lost wages continues past the waiting period, the lost wages incurred after this waiting period will be covered. If the disability continues past *four (4) weeks*, the lost wages incurred from the beginning of the disability will be covered. This two (2) week period is known as the "retroactive period."

In addition to the percentage of wages payable and the period of payment, state workers compensation laws evaluate the nature of the disability in question when making awards. Injuries are seen as being permanent or temporary in duration; total or partial, in severity.

As a result, there are four classifications of disability:

* permanent total disability;
* temporary total disability;
* permanent partial disability;
* temporary partial disability.

Permanent total disability is the most severe: the employee will never work again. As a result, benefits are paid for life.

Temporary total disability renders the employee incapable of working for a given time, but recovery is seen. An example of this classification would be a severely sprained back rendering the employee immobile for 4-6 weeks, but capable of returning to work with no permanency.

Permanent partial disability usually involves an injury which is permanent in nature (loss of an arm, leg, etc.), but will not stop the employee from returning to work.

Temporary partial disability is the least severe classification of disability and usually characterizes an injury that keeps the employee out of work for a few days (example: sprained neck). "Light duty" can be given to such a disability.

Death Benefits include an amount for funeral benefits mandated by law ($2,500 in Alaska) as well as survivors' or dependents' benefits.

G. Supplementary Benefits

In addition to paying benefits to employees, the Workers Compensation coverage will defend the insured employer for legal actions arising out of these payments.

For example, an injured employee might disagree with the type of treatment allowed under workers compensation insurance or the amount of settlement. In such circumstances, the

employee might retain an attorney and seek further reimbursement.

Part One - Workers Compensation Insurance agrees to investigate such cases, then defend or settle them as needed.

In addition to the *benefits* payable under this section, Part One - Workers Compensation Insurance agrees to pay:

* reasonable expenses incurred at the company's request, but not loss of earnings;
* premiums for bonds to release attachments and for appeal bonds in bond amounts up to the amount payable under this insurance;
* litigation costs taxed against the insured;
* interest on a judgment as required by law until the company offers the amount due under this insurance;
* expenses the company incurs.

H. Duties of Employer

The insured employer is responsible for any payment *in excess* of the benefits regularly provided by the workers compensation law including those required because:

* of the insured's serious and willful misconduct;
* the insured knowingly employs an employee in violation of law;
* the insured fails to comply with a health or safety law or regulation; or
* the insured discharges, coerces or otherwise discriminates against any employee in violation of the Workers Compensation law.

The following are duties of employers as required by Alaska's insurance code:

* No contract may be awarded by the state or a home rule or other political subdivision of the state unless the person to whom the contract is to be awarded has submitted to the contracting agency proof of current coverage by workers compensation insurance or proof of a current certificate of self-insurance from the board. The person to whom the contract is awarded must keep his workers compensation insurance policy in effect during the life of the contract with the state or political subdivision. If the state or the political subdivision of the state fails to obtain proof of coverage or self-insurance and an employee of the contractor is injured during the term of the contract, the state or political subdivision is liable for workers compensation to the employee if the employee is unable to recover from the employer because of the employer's lack of financial assets. The state or political subdivision is not liable, however, to the employee for workers compensation if the employee can recover from the employer.
* When a contracting agency of the state or a political subdivision receives notice that the workers compensation insurance policy of an employer to whom the agency has awarded a contract has been cancelled due to nonpayment of a premium, without being replaced by a comparable policy, the agency may either terminate the contract with the employer or continue the premium payments on his/her behalf in order to keep the policy in force during the life of the agency's contract. If the agency chooses to keep the policy in force, it may deduct its payments from the contract price or bring an action against the employer to recover the amount of the payments. When the contracting agency receives notice that the board has revoked a certificate of self-insurance held by a person to whom a contract has been awarded, the agency may terminate the contract. This subsection does not limit the causes of action or remedies which the state or political subdivision may have against the employer.
* The liability of an employer for medical treatment is not affected by the fact that his/her employee was injured through the fault or negligence of a third party not in the same employ. The employer has, however, a cause of action against the third party to

recover any amounts paid by the employer for the medical treatment.

* *The liability of an employer is exclusive* and in place of all other liability of the employer and any fellow employee to the employee, his/her legal representative, husband or wife, parents, dependents, next of kin, and anyone otherwise entitled to recover damages from the employer or fellow employee at law or in admiralty on account of the injury or death. However, if an employer fails to secure payment of compensation as required by law, an injured employee or his/her legal representative in case death results from the injury may elect to claim compensation or to maintain an action against the employer at law or in admiralty for damages on account of the injury or death. In that action, the defendant employer may not plead the "three common law defenses."

* Employer's Notice of Insurance

  You and each of you are hereby notified that the undersigned is insured in the ..... Insurance Company, whose address is ..... and that the period covered by the insurance ..... in accordance with the terms, conditions and provisions to pay compensation to employees of the undersigned for injuries received as provided in the act of the State of Alaska, known as the "Alaska Workers Compensation Act."

* An employer must keep a record in respect of any injury to an employee. Th record must contain the information of disease, other disability, or death in respect to an injury which the board requires, and must be available to inspection by the board or by a state authority at the times and under the conditions which the board prescribes by regulation.

* Within ten (10) days from the date the employer has knowledge of a disease or infection, alleged by the employee or on his/her behalf to have risen out of and in the course of the employment, the employer must send to the board a report setting out:

  the name, address, and business of the employer;

  the name, address, and occupation of the employee;

  the cause and nature of the alleged injury or death;

  the year, month, day, and hour when and the particular locality where the alleged injury or death occurred; and

  the other information which the board may require.

* An employer who fails or refuses to send a report required of him/her or who fails or refuses to send the report within the time required must, if so required by the board, pay the employee or his/her legal representative or other person entitled to compensation by reason of the employee's injury or death *an additional award equal to 20% of the amounts which were unpaid when due.* The award must be against either the employer or his/her insurance carrier, or both.

  An employer who fails to insure or fails to obtain a certificate of self-insurance from the board, upon conviction, *is punishable by a fine of not more than $1,000, or by imprisonment for not more than one year, or both.* If an employer is a corporation, all persons who, at the time of the injury or death, had authority to insure said corporation or apply for a certificate of self-insurance, and the person actively in charge of the business of such corporation may be subject to the penalties and may be personally, jointly, and severally liable together with the corporation for the payment of all compensation or other benefits for which the corporation is liable if said corporation at such time is not insured or qualified as a self-insurer.

* In an action by an employee against an employer for personal injury sustained arising out of and in the course of the employment where the employer has failed to insure or to provide security, it is presumed that the injury to the employee was the first result

growing out of the negligence of the employer and that the employer's negligence was the proximate cause of the injury. *The burden of proof rests upon the employer to rebut this presumption of negligence.*

* If an employer fails to insure or provide security as required, the board may issue a *stop order* prohibiting the use of employee labor by the employer until the employer insures or provides security. *If an employer fails to comply with a stop order, the board may assess a civil penalty of $1,000 per day.* The employer may not obtain a public contract with the state or a political subdivision of the state for three (3) years following the violation of the stop order.
* An employer must give evidence of compliance within ten (10) days after the termination of his/her insurance by expiration or cancellation. These requirements do not apply to an employer who has certification from the board of his/her financial ability to pay compensation directly without insurance.
* The employer must furnish medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus for the period which the nature of the injury or the process of recovery requires, *not exceeding two (2) years from and after the date of injury to the employee.* However, if the condition requiring the treatment, apparatus, or medicine is a latent one, the two-year period runs from the time the employee has knowledge of the nature of his/her disability and its relationship to his/her employment and after-disablement. If continued treatment or care or both beyond the two-year period is indicated, the injured employee has the right of review by the board.
* If at any time during the period the employee unreasonably refuses to submit to medical or surgical treatment, the board may by order suspend the payment of further compensation while the refusal continues. No compensation may be paid at any time during the period of suspension, unless the circumstances justified the refusal.
* Interference by a person with the selection by an injured employee of an authorized physician to treat him/her, or the improper influencing or attempt by a person to influence a medical opinion of a physician who has treated or examined an injured employee is a *misdemeanor.*

I. General Provisions

The following statements apply to Workers Compensation Insurance in Alaska:

* Employers must report work-related accidents resulting in injury or death within ten (10) days.
* An employee's notice of an accident to his/her employer constitutes notice to the insurance company.
* An employer must report all work-related accidents of employees upon threat of a penalty.
* Benefits are paid directly to the employee, not employer.
* Employers must post a notice in a "common area" frequented by employees that they (the employers) provide workers compensation insurance and/or are required to do so by state law. This rule is intended to inform workers of their rights as well as facilitate the accident reporting process between employee and employer, employer and insurer.
* A *Second Injury Fund* has been established in Alaska to encourage the hiring of employees physically handicapped from a prior work-related accident.
* Compensation may not be allowed for an injury:

- proximately caused by the employee's willful intent to injure or kill any person;
- proximately caused by intoxication of the injured employee or proximately caused by

the employee being under the influence of drugs unless the drugs were taken as prescribed by the employee's physician.

An individual who is enrolled for credit at a public high school in a course which combines academic instruction with work experience outside the school for a public or private nonprofit employer is an employee of the state while he/she is performing the work experience.

* An executive officer elected or appointed by a corporation, other than an official of a municipal corporation or a charitable, religious, educational, or other nonprofit corporation, is an employee of the corporation. However, an executive officer of a corporation may waive coverage, subject to the approval of the Commissioner of Labor.

* A special police officer is considered an employee only when he/she is actually traveling or working as a special officer.

A member of a state board or commission is considered an employee only while he/she is actually traveling or working as a member of the board or commission.

* For the purposes of workers compensation, any injury, disability or death incurred by a fireman by reason of his/her proceeding to or engaging in a fire suppression or rescue operation, or the protection or preservation of life or property, anywhere in the state is considered to have risen out of and been sustained in the course of employment. The fire department or regularly organized volunteer fire department of his/her primary employment or registration is considered to be the employer, except when the injured, at the time of injury or death, is acting for compensation from another.

A resident of Alaska temporarily engaged in a civil defense or disaster relief function in another state or country is considered an employee of the state.

An agreement by an employee to pay a portion of the premium paid by his/her employer to a carrier or to contribute to a benefit fund or department maintained by the employer for the purpose of providing compensation or medical services and supplies is not valid. An employer who makes a deduction for this purpose from the pay of an employee entitled to workers compensation benefits is guilty of a *misdemeanor.* Upon conviction, this employer is punishable by a fine of not more than $1,000.

* An agreement by an employee to waive his/her right to compensation is not valid.

* A person who willfully makes a false or misleading statement or representation for the purpose of obtaining or denying a benefit or payment is guilty of theft by deception and is punishable as provided by law.

* An employer required to secure the payment of compensation who fails to do so is guilty of:

a class B felony if the amount involved exceeds $25,000; or

a class C felony if the amount involved is $25,000 or less.

If the employer is a corporation, its president, secretary, and treasurer are also severally liable to the fine or imprisonment imposed for the failure of the corporation to secure the payment of compensation.

A person is guilty of a *misdemeanor*, and upon conviction is punishable for *each offense by a fine of not more than $1,000*, or by imprisonment for not more than one (1) year, or by both, if he/she:

receives a fee, other consideration, or a gratuity on account of services rendered in respect to a claim, unless the consideration or gratuity is approved by the board or the court; or

makes it a business to solicit employment for a lawyer or for himself/herself in respect to a claim or award for compensation.

J. Part Two - Employers Liability Insurance

Under Part One - Workers Compensation Insurance, the policy provides statutory medical, lost wages and death benefits. Under Part Two - Employers Liability Insurance, the policy pays for damages resulting from B.I. claims initiated by employees.

Under Part One, payments are made *regardless* of fault. Under Part Two, negligence must be established in order for payment to be made.

It is important to remember that this coverage protects the insured employer from negligence suits brought by employees because of work-related injuries. It is very specialized in its scope.

K. How Coverage Applies

Employers Liability Insurance applies to bodily injury by accident or bodily injury by disease. Bodily injury includes resulting death. Remember:

* The bodily injury must arise out of and in the course of the insured employee's employment.
* The employment must be necessary or incidental to the insured's work in a state or territory listed in the Information Page.
* Bodily injury by accident must occur during the policy period.
* Bodily injury by disease must be caused or aggravated by the conditions of employment. The employee's last day of last exposure to the conditions causing or aggravating such bodily injury by disease must occur during the policy period.
* If the insured is sued, the original suit and any related legal actions for damages for bodily injury by accident or by disease must be brought in the United States of America, its territories or possessions, or Canada.

L. Part Two - Exclusions

As with any liability coverage, there are exclusions inserted to define coverage. Employers Liability coverage does *not* apply to:

* liability assumed under a contract;
* punitive or exemplary damages because of bodily injury to an employee employed in violation of law;
* bodily injury to an employee while employed in violation of law with the insured's actual knowledge;
* any obligation imposed by a workers compensation, occupational disease, unemployment compensation, or disability benefits law, or any similar law;
* bodily injury intentionally caused or aggravated by the insured;
* bodily injury occurring outside the United States of America, its territories or possessions, and Canada. This exclusion does not apply to bodily injury to a citizen or resident of the United States of America or Canada who is temporarily outside these countries;
* damages arising out of the discharge of, coercion of, or discrimination against any employee in violation of law.

Employers Liability Insurance is written with separate limits of liability for:

* B.I. per accident;
* B.I. by disease - policy limit;
* B.I. by disease - per employee.

Obviously, the first limit applies to work-related bodily injury sustained by an employee in an accident.

When a disease is involved, there is a policy limit and an employee limit that applies to each occurrence.

M. Part Three - Other States Insurance

Part Three - Other States Insurance covers the insured employer for his responsibilities mandated by the workers compensation law of a state(s) *other than* those listed on the Information Page. It covers workers compensation situations arising in states where the insured employer had *not foreseen* activity.

In summary, if the insured employer had foreseen involvement in a given state at the inception of the policy, he should have listed this state on the Information Page.

This protection is important for employers with expanding interstate operations.

N. Part Four - Your Duties if Injury Occurs

If an injury occurs to a covered employee, the employer must notify the insurance company immediately.

In addition, the insured employer must agree to the following duties:

* provide for immediate medical and other services required by the workers compensation law;
* give the company or its agent the names and addresses of the injured persons and of witnesses, and other information it may need;
* promptly give the company all notices, demands and legal papers related to the injury, claim, proceeding or suit;
* cooperate with the company and assist it as it may request, in the investigation, settlement or defense of any claim, proceeding or suit;
* do nothing after an injury occurs that would interfere with the company's right to recover from others;
* do not voluntarily make payments, assume obligations or incur expenses, except at your own cost.

O. Workplace Safety

Workplace safety is a major objective of workers compensation insurance and is accomplished by:

* the availability of *safety engineering programs* provided by insurers for insured employees;
* the application of *monetary incentives* (premium discounts) for the implementation of recommended safety programs by insureds granted by the Division of Workers Compensation, Department of Labor.

Safe workplaces benefit everyone: insurer, insured and especially covered workers.

Finally, in order for a business to self-insure in Alaska for its workers compensation obligation, it must obtain a *certificate of authority* from the Department of Labor.

P. Workers Compensation Law

As previously noted, because employee well-being is so integral to the economic well-being of the country, each state has its own workers compensation laws today, social legislation designed to provide guidelines for medical care, cash benefits and rehabilitation services for workers sustaining work-related injuries.

In addition to the state workers compensation legislation, there are a number of federal laws governing work-related injuries of certain groups of employees:

* the Federal Employees Compensation Act (F.E.C.A.);
* the Longshore and Harbor Workers Compensation Act;
* the Federal Employers Liability Act (F.E.L.A.);
* Jones Act.

The *Federal Employees Compensation Act (F.E.C.A.)* governs the work-related compensation cases of *all civilian employees of the United States government*. All private employment in the District of Columbia and employment outside the United States by contractors at U.S. military bases are also covered by this act.

The Longshore and Harbor Workers Compensation Act governs the work-related compensation cases of all U.S. maritime employees and certain other employees (longshoremen, harbor workers, ship builders, etc.). It does not cover masters and members of the crew of a vessel (refer to the Jones Act). It's a compulsory law administered by the Department of Labor. An employer's liability under the Longshore and Harbor Workers Compensation Act may be covered under the standard Workers Compensation and Employees Liability policy by attachment of an endorsement of the same name that provides the coverage required by the Act.

The *Federal Employers Liability Act* (also known as F.E.L.A.) governs the work-related compensation cases of *interstate railroad workers*. This act requires interstate (not intrastate workers: railroad employees who work in one state) railroad workers to demonstrate that employer's negligence contributed to their injuries.

Finally, *the Jones Act* (Merchant Marine Act of 1920) governs the work-related compensation cases of masters and members of crews of vessels (shippers and sailors). This law does not apply to U.S. employees operating sailing vessels. Liability under admiralty law for the operation of vessels, marine diving, dredging, oyster boating, salvage operations, marine wrecking and other boat-related activities may be covered under a Workers Compensation and Employers Liability policy endorsed with a Maritime Coverage form. This endorsement modifies the insurance provided under the Employers Liability section of the policy to address bodily injuries to masters or members of the crews of vessels.

Q. Workers Compensation Assigned Risk Pool of Alaska

(1) Purpose

The Workers Compensation Assigned Risk Pool of Alaska was created to provide workers compensation insurance to individual employers unable to obtain same in the voluntary market.

(2) Eligibility

All Alaska employers who can provide evidence of rejection of coverage from the voluntary market are eligible to be insured under this plan. The reason for rejection of coverage cannot be:

* non-payment of premium;

  non-compliance with basic safety regulations.

(3) Application Procedures/Binding Requirements

An employer who has been rejected for workers compensation insurance may apply to the Alaska Assigned Risk Pool for coverage under the Assigned Risk Pool.

If this employer complies with all health, safety and welfare rules governing his/her line of business, he/she will be assigned to an insurer in the pool which will issue a policy to the

employer. All workers compensation insurers doing business in Alaska must belong to the Assigned Risk Pool and write insurance in the pool in direct proportion to the amount they write in the voluntary market as compared with all other insurers writing this business in this state.

Alaska's Workers Compensation Assigned Risk Pool may surcharge an insured up to 25% of the regular premium.

(4) Workers Compensation Board

The Alaska Workers Compensation Board consists of a number of panels representing specific geographic areas of these state. Each panel must include the Commissioner of Labor, a representative of industry and a representative of labor. The latter two members of a panel are appointed by the governor.

A workers compensation claim may be heard by only one panel.

(5) Executive Officers Waiver

An "executive officer" is an executive elected or appointed and empowered in accordance with the bylaws of a corporation and considered an employee of that corporation. This definition does not include officials of municipal corporations or charitable, religious, educational or non-profit organizations.

Executive officers of corporations may waive workers compensation coverage, subject to the approval of the Commissioner of Labor.

1. DEFINITIONS

The following definitions are found in Alaska Insurance regulations:

* property insurance;
* casualty insurance;
* surety insurance;
* marine, wet marine and transportation;
* surplus lines insurance;
* business/commercial insurance;
* nonpayment of premium;
* personal auto insurance;
* personal insurance;
* renewal.

A. Property Insurance

"Property insurance" is insurance on real or personal property of every kind and for every insurable interest, whether on land, water or in the air, against:

* loss or damage from any and all hazard or cause;
* consequential loss other than noncontractual legal liability.

Title insurance is *not* included within the definition of property insurance.

B. Casualty Insurance

"Casualty insurance" includes:

* vehicle insurance (including automobile insurance and aircraft insurance);
* liability insurance;
* workers compensation and employers liability insurance;
* burglary and theft;
* credit insurance;
* malpractice insurance; and
* other miscellaneous types of insurance.

C. Surety Insurance

"Surety insurance" includes:

* fidelity insurance;
* surety bonds;
* crime insurance.

D. Marine, Wet Marine and Transportation Insurance

The Nation-Wide Marine Definition describes the kinds of risks that may be written under marine, inland marine, or transportation insurance as follows:

* imports;
* exports;
* domestic shipments;

* bridges, tunnels, and other instrumentalities of transportation and communication;
* personal property floater risks;
* commercial property floater risks.

An *import* is property that "has not become incorporated and mixed with the general mass of property in the United States." This property retains its import status until:

* sold and delivered by the importer;
* removed from storage and placed on sale by the importer;
* delivered for manufacture, process or other use.

Exports are property "designated or prepared for export unless diverted for domestic trade."

Domestic shipments are property on consignment, for sale, in transit or in the custody of anyone *other* than the owner. If in the custody of the owner, this Property would be the rightful subject of some other form of property insurance.

As a result, property located at the manufacturer's plant and/or premises owned, leased or operated by the owner or buyer is not covered as a domestic shipment.

The Nation-Wide Definition of bridges, tunnels and other instrumentalities of transportation and communication includes:

* bridges, tunnels and similar instrumentalities;
* piers, wharfs, docks, slips, etc.;
* pipelines;
* power transmission, telephone and telegraph lines;
* radio and television communication equipment;
* outdoor cranes and similar equipment.

Of course, buildings, their improvements and betterments, furniture, fixed contents and supplies are *not* included under this category. Such property rightfully is the subject of fire insurance and similar contracts.

A *floater* is coverage on property that moves or "floats" from one location to another. Floaters can be personal or commercial.

E. Surplus Lines Insurance

"Surplus lines insurance" means any insurance in this state of risks resident, located or to be performed in this state, permitted to be placed through a surplus lines broker *with a nonadmitted insurer* eligible to accept insurance, other than:

* reinsurance;
* wet marine and transportation insurance;
* insurance independently procured;
* life insurance;
* disability insurance and annuity contracts.

"Surplus lines broker" means a person licensed to place insurance of risks resident, located or to be performed in this state with eligible surplus lines insurers.

F. Business/Commercial Insurance

"Business insurance" provides coverage to commercial endeavors as opposed to personal insurance needs. Examples of business insurance covered in this textbook are:

* Commercial Building/Personal Property form;

TERMS

POLICY TERMS AND PROVISIONS

The following terms and concepts are significant in general, but particularly at the time of loss settlement:

- accident;
- occurrence;
- deductible;
- indemnity;
- replacement cost;
- actual cash value;
- limits of liability;
- coinsurance;
- extensions of coverage;
- additional coverage;
- pair and set clause.

Accident v. Occurrence

Property and casualty contracts are usually written in one of two ways:

- accident-basis;
- occurrence-basis.

An *accident* is a sudden, unexpected, unforeseen event resulting in financial loss. Examples: Woman falls on cracked sidewalk. Car A hits car B. Lightning strikes a house causing a fire.

An *occurrence* is a sudden, unexpected, unforeseen event resulting in financial loss (an accident) *including* repeated and continuous exposure to conditions.

Examples: Industrial waste gradually pollutes a river. Exhaust from trucks idling at a trucking company each morning destroys a nearby garden. An insured worker gradually becomes ill due to repeatedly handling asbestos on the job.

When reviewing the facts of a loss, one must consider whether the insurance policy involved is written on either an accident or an occurrence basis. Also, one must remember that the definition of occurrence *includes* the definition of accident. As a result, the term "occurrence" is more comprehensive than the term "accident."

Deductibles

Property contracts usually contain a *deductible* clause whereby the company agrees to pay a claim after it exceeds a given amount (flat deductible) or percentage amount (percentage deductible).

Deductibles are encouraged by the company to preclude the submission of minor dollar claims that cost an inordinate amount of money to process.

For example, most automobile collision coverages are written with a deductible to prevent the insured from submitting bills for every little parking lot scratch. Such claims would require an enormous staff to process and require other administrative expenses which would make the cost of collision insurance prohibitive.

If an insured incurs a $250 loss under a given policy and carries a $200 deductible, the insured would be eligible to recover $50 for the loss. Deductibles usually apply to each loss; however, certain types of policies (accident and health insurance) provide annual deductibles.

Indemnity

Property insurance contracts are called *contracts of indemnity*: their purpose is to reimburse an insured for a covered loss, thereby restoring the insured to the financial position which he/she enjoyed prior to the loss. To indemnify means to compensate or reimburse.

Because property insurance contracts are based on the principle of indemnity, insureds are not supposed to profit from their insurance. As a result, it is contrary to the principle of indemnity for an insured to collect twice for the same loss. In this way, the insured would be making a profit and, thereby, be put in a better position than he/she enjoyed prior to the loss.

RC v. ACV

Property claims usually are settled in one of two ways:

- replacement cost (RC);
- actual cash value (ACV).

Replacement cost (RC) is defined as the amount of money it would cost to replace a damaged or destroyed item with one of like kind and quality.

In contrast, *actual cash value (ACV)* is defined as replacement cost minus depreciation.

If a couch were destroyed in a covered loss and settlement were to be made on an ACV basis, the adjustor would determine how much that couch would cost in today's market then deduct an amount that would reflect depreciation. If this same loss were to be settled on a replacement cost basis, no deduction would be made for depreciation.

Buildings insured under property contracts usually are insured on a replacement cost basis to reflect the fact that they increase in value over time (in most cases). In contrast, most contents of these buildings are written on an ACV basis because coverage on an RC basis is very expensive usually.

Limit of Liability

The *limit of liability* of a particular policy governs settlement. An insurance company's limit of liability on a policy is the maximum amount that insurer will pay under that policy for any one loss.

As we shall see in our study of property and casualty contracts, the company's limit of liability toward the insured is governed by the particular contract in question.

For example, the Homeowners Policies apply specific "limits of liability" or dollar figures to reimbursement for certain types of property such as guns or stamps. Why? To provide the lowest possible premium, the insurer bases coverage on the amounts of this type of property (guns, stamps, etc.) that the "ordinary" person carries. If greater amounts of coverage are needed, they can be obtained for additional premium.

In most cases, the insurance company will never pay more than the face amount of the contract: the amount of coverage listed in the Declarations of the insurance contract.

Coinsurance

A *coinsurance clause* is found in most property policies requiring the insured to carry a specified amount (described as a percentage) of the value of the insured property.

If the coinsurance clause is satisfied, partial losses will be paid in full. If the coinsurance clause is *not* satisfied, partial losses will be subject to payment through the following formula:

$$\frac{\textit{Amount of Insurance Carried}}{\text{Amount of Insurance Required}} \times \text{Loss} = \text{Settlement}$$

For example, assume the following:

Value of Building	$100,000
Coinsurance %	80%
Loss	$60,000
Amount of Insurance	$80,000

In this case, the amount of insurance carried is the same as the amount required so these $80,000 amounts cancel each other out. As a result, the $60,000 loss would be paid in full.

When dealing with these property settlements, the amount paid can never exceed:

- the limits of the insurance policy;
- the actual amount of the loss;
- the dollar amount determined by the coinsurance formula.

Extensions of Coverage/Additional Coverages

If the insured satisfied the *coinsurance clause* applicable to a given property policy, he/she often may elect to provide a certain amount of his/her coverage to property not normally covered by the policy as *Extensions of Coverage.*

For example, if 80% or higher coinsurance applies, the insured may apply up to $5,000 of the Building and Business Personal Property coverage to insured property off-premises, subject to certain guidelines.

Additional Coverages are just that: coverages provided under a property policy that are "in addition" to the main coverages.

For example, under the Building and Personal Property Coverage form, "debris removal" is provided as an *additional coverage.* As a result, payment of expenses for removal of debris after a covered loss will be made to the insured (subject to policy limits).

As their names suggest, coverage extensions "extend" existing coverages to apply to new situations; "additional coverages" are provided *in addition to* the existing coverages. These fine destinctions will become clearer as we discuss the various property contracts.

Pair and Set Clause

Finally, a *pair and set clause* appears in many property policies describing how a claim should be handled when one item of a pair or set is damaged, lost or destroyed. Specifically, loss to one item of a pair or set does not constitute loss to the entire pair or set.

For example, loss to one gold earring will not entitle the insured to reimbursement for the pair of gold earrings. The insured will be reimbursed only for the resulting decrease in value.

POLICY PROVISIONS

Some of the more important general provisions found in insurance policies include:

- appraisal;
- other insurance;
- assignment;
- subrogation;
- arbitration;
- cancellation/nonrenewal;
- vacancy/unoccupancy;
- right of salvage;
- abandonment.

Appraisal

If the insured and insurer cannot agree on a settlement amount in a property loss, each is required to obtain an independent *appraisal* and share in the cost of an umpire to settle the dispute.

The decision of the umpire is final and binding.

Pro Rata Liability

If more than one insurance policy is written on a piece of property, each policy must pay its proportionate share of the loss in keeping with the principle of indemnity. The formula for *other insurance (pro rata liability)* is:

$$\frac{\textit{Company Amount}}{\text{Total Amount}} \times \text{Loss} = \text{Amount a Company Will Pay}$$

For example, a property valued at $100,000 and insured under two similar policies (Policy A — $60,000; Policy B — $40,000) would receive the following settlements in the event of a $30,000 loss:

Policy A	=	$\frac{\$60,000}{\$100,000}$	X	$30,000	=	$18,000
Policy B	=	$\frac{\$40,000}{\$100,000}$	X	$30,000	=	$12,000
TOTAL SETTLEMENT:						$30,000

Assignment

Assignment of rights and coverages is not permissible under property contracts without the consent of the company. If an insured sells his house to another, he cannot transfer his homeowner's coverage to the new owner automatically. The company must approve the transfer.

The assignment clause is inserted into most property contracts to reflect the fact that individual owners as well as individual properties are being insured: the same property in the hands of different individuals would provide different exposures for the company.

Subrogation

Subrogation is a process by which the insurance company, after paying its insured for a loss, assumes that insured's rights to recovery against a responsible third party.

For example, if an insurer paid its insured for rear end auto damage caused by a responsible third party, the insurer could then subrogate against or attempt to recover monies from the party who hit the insured in the rear.

In addition, subrogation reinforces the idea that an insured *cannot* collect twice for the same loss: once, from his company; a second time, from the responsible party.

Arbitration

Arbitration is a process by which insurance companies usually settle their differences when one company subrogates against another.

For example, Jones hits Smith in the rear in an auto accident. Smith, wanting his car repaired quickly, goes to his own insurance and receives settlement under his collision coverage. Smith's company would then subrogate against Jones' company for recovery. If Jones' company refused to settle this subrogation claim voluntarily, Smith's company would take Jones' company to arbitration.

The decision at arbitration is final and binding.

Cancellation/Nonrenewal

Each property and casualty policy details the reasons for which the insurer can cancel the policy. These reasons must be in compliance with individual state laws.

In contrast, insureds can cancel their policies for any reason at any time.

If the insurance company *cancels* a policy, any unearned premium will be returned on a pro rata basis (no deduction made for service fees, etc.). As a result, if a six-month policy were cancelled after five months, the insured would be entitled to 1/6th of the policy premium (if paid).

In contrast, if the insured cancelled the policy, unearned premium would be returned on a short rate basis (with deduction made for servicing the policy, etc.).

Nonrenewal occurs when the insurer decides not to renew coverage with a given insured. By definition, it occurs at the end of a policy period.

Vacancy/Unoccupancy

Property contracts are very concerned with covering buildings that are left vacant or unoccupied.

"Vacancy" refers to a building which is unfurnished and not being used as a dwelling or for business.

"Unoccupied" refers to a building which is furnished, but not being used as a dwelling or for business.

When reviewing the individual property contracts treated in the next section, be aware how each treats vacancy and unoccupancy.

Right of Salvage/Abandonment

If the insurance company pays its insured in full to replace a given item of property, the company thereby retains the *right of salvage* to that property. In this way, the insurance company can reduce its losses in the matter by selling the salvage to a salvage dealer.

Of course, the decision to reimburse the insured for a given piece of property and then sell the property as salvage is the insurance company's decision alone. The insured cannot *abandon* (give) the property to the insurance company and demand total reimbursement. The insurance company, by contract, has the right to settle the loss by payment or repair or outright replacement of the property involved.

NEGLIGENCE

LIABILITY BASICS

Preview

Four Elements of Negligence:

- Duty;
- Failure to live up to duty;
- Injury;
- Proximate cause.

Common General Liability Exposures:

- Premises;
- Operations;
- Products;
- Completed Operations;
- Contracts;
- Contingent Liability;
- Personal Injury;
- Advertising Injury.

LIABILITY BASICS

Negligence

The law imposes a duty on everyone to act in a manner that will preserve the harmony of society. Care must be taken not to injure another person or that person's property. What kind of care? The care that a "reasonable and prudent man" would exercise in a given situation.

What is a "reasonable and prudent man"? Good question. Basically, the reasonable and prudent man concept is an offspring of common law: He is different things to different people in different situations in different parts of the country.

When there is no definite statute to guide us and there is a question concerning the possible negligent behavior of an individual, that person is compared to the reasonable and prudent man yardstick or a particular jury's concept of it.

There is no concrete definition of what a reasonable and prudent man is nor should there be one: Society and its standards are constantly changing. If a jury feels an individual did not act in a reasonable and prudent manner in a particular situation, it will declare this individual negligent.

Negligence can be seen as an unreasonable or imprudent act. it might be a thoughtless or careless act or one committed out of ignorance. It may even be a non-act or omission, but it is *never an intentional act.* Such acts, known as intentional torts (legal wrongs), are *not* the subject of negligence.

Finally, before an act can be declared negligent, there must be four elements present *simultaneously*:

- the existence of a *duty* to act in a certain way;
- a *failure* to live up to this duty;
- an actual *injury* must occur;
- the failure in duty must be the *proximate cause of the injury.*

Duty

When you drive a car around town, you have a duty to operate the vehicle in a safe, reasonable manner and abide by all traffic regulations. When you own a home, you have a duty to maintain it and its walkways to accommodate safe, public traffic. If you own a business, you have a duty to provide safe quarters for your customers and employees alike.

A duty is an obligation one owes to society which is reinforced, explicitly or implicitly, by law. Duties or obligations are connected to the roles we assume. They "come with the territory."

For example, you think you're a pretty good cook and want to make a living as a restaurateur. Opening night, ten people develop gastritis from your famous stew. "Coincidence," you say. "Negligence," the jury will say. Why? There are four elements of negligence present.

Failure

As a restaurateur, you have a responsibility to your customers to serve them food that is not only palatable, but safe for human consumption. Obviously, your stew wouldn't measure up to what a reasonable and prudent man would have prepared under similar conditions.

And, as a restaurateur, you have a duty to your customers to provide them with a safe place to eat. Falling ceilings, cracked floors, and broken furniture would not be a part of the ambience maintained by a reasonable and prudent man.

You had *duties* as a restaurateur to provide food that is "safe" in an atmosphere that is "safe" and you *failed*. You're two for two with the elements of negligence.

Injury

Now you're three for three. The stew should have been safe for human consumption, but it wasn't. Why? Ten cases of gastritis don't lie.

As the owner of the restaurant, it was your duty to cook or to supervise the cooking to ensure that it was safe. Injuries occurred as a result of the consumption of this food. Therefore, you failed in your duty.

Proximate Cause

"Proximate cause" has been defined as an act, through an uninterrupted chain of events, that can be determined to be the immediate or actual cause of a loss.

In the restaurant example, your failure in duty to provide "safe food" was the *proximate cause* of injury (gastritis) to ten patrons. It wasn't their subsequent visit to the theatre at which they all consumed one glass of wine. It wasn't the rainy night air. It was your food that made them sick.

Damages

Before concluding our discussion of negligence, we must treat the end result of a successful negligence suit: the awarding of damages.

Mr. A, a depositor of the Last National Bank, was on his way into the bank to deposit some money when he fell on the sidewalk in front of the bank on a deposit of another sort: nails. Apparently, the nails were dropped by the construction crew that was being employed to renovate the facade of the bank. Mr. A fell and broke his arm.

If you were in a position to award Mr. A damages, what would you do? First thing, you would probably ask for a definition of the word "damages" as it is used in negligence cases. Simply stated, damages are a sum of money awarded to a person injured by the tort of another.

Awards may be compensatory or punitive, depending on whether they are awarded as the measure of the actual loss suffered or as punishment for an act that society wishes to deter.

Compensatory damages are awarded on the basis of two considerations:

- special damages;
- general damages.

Special damages are the actual, out-of-pocket bills incurred by an individual as a result of an accident. In Mr. A's case, special damages, or "specials" as they are known in legal parlance, are:

• medical bills —	$2,500
• prescriptions, sling —	100
• new pants —	40
TOTAL:	$2,640

Again, these bills were incurred as a proximate cause of the accident. They reimbursed Mr. A for his "out of pocket" expenses as a result of this accident.

General damages are awarded to compensate an individual for the non-monetary losses or inconveniences that resulted from an accident. Mr. A's fall not only resulted in a broken arm and

a torn pair of pants. It also made it impossible for him to engage in softball which is his favorite recreation. It made it difficult for him to shave, brush his teeth, and a few et ceteras. Mr. A needs compensation for these inconveniences if justice is to be served.

Punitive damages may be charged against a plaintiff who has committed an outrageous act in the eyes of the law and needs to be punished. The amount of the fine is commensurate with the outrageous nature of the act. Cases involving strict or absolute liability (e.g. use of explosives; training wild animals) often involve punitive damages. Generally, punitive damages are awarded only if compensatory or actual damages have been sustained.

In Mr. A's case, compensatory damages would be awarded because he sustained an injury as the result of another's tort. If the presence of the nails in this case resulted from a practice of this construction company's workers throwing bent nails over their shoulders, the court might decide to award Mr. A punitive damages. Why? To punish the construction company employees for their behavior and to deter future acts of this sort.

COMMON LIABILITY EXPOSURES

As different as one business is from another, all businesses have certain *common* commercial liability exposures such as:

- premises;
- operations;
- products;
- completed operations;
- contracts;
- contingent liability;
- personal injury;
- advertising injury.

We shall review each of these exposures in detail before discussing the insurance coverages which are designed to address them.

Premises

The most basic exposure of any individual engaging in business involves the business premises. Owners or tenants of buildings may be held liable for damages to people injured or property damaged while on "the premises."

Customers. Salesmen. Postal workers. Repairmen. There is no end to the possible combinations of people and their reasons for entering upon a given piece of property. The specifics of accidents vary, but one fact remains constant: the owner(s) and occupant(s) of the property are held responsible for its condition. And even this statement must be qualified.

The landlord (owner of real property) — tenant (occupier) relationship varies as much by jurisdiction as it does by contract. Like any other contract, a lease agreement is subject to a "mutuality of agreement" between the parties concerned: There is no such thing as a standard lease. As a result, any discussion of negligence in connection with the "occupancy, maintenance, or use" of a given piece of real property must begin with an examination of the lease.

Most lease agreements outline the transfer of property from owner to tenant for a given time period. In general, the landlord is under no obligation to:

AUTO INSURANCE

AUTOMOBILE INSURANCE

P.A.P. LIABILITY and MEDICAL PAYMENTS

Preview

Personal Auto Policy (P.A.P.) — designed to address the various risks associated with the personal use of an auto.

P.A.P. Covered Autos:

- private passenger auto, pickup or van shown in Declarations;
- covered auto acquired during policy period;
- any trailer the insured owns;
- temporary substitutes.

Part A — Liability:

- BI and PD Liability;
- Supplementary Payments including cost of legal defense;
- Excludes loss caused by:
  - — workers' compensation claims;
  - — use of vehicle as a livery;
  - — the automobile business;
  - — intentional acts.

Part B — Medical Payments covers:

- the named insured and family as passengers and pedestrians;
- other passengers of the insured auto.

AUTOMOBILE INSURANCE
LIABILITY and MEDICAL PAYMENTS

Introduction

Along with general liability and workers' compensation, automobile liability is one of the three major divisions of liability insurance. It addresses the third party claims for bodily injury and property damage arising out of the insured's negligent operation of an automobile.

Just as the Homeowners Program packages the property coverages of Section I with the liability coverages of Section II, there are a number of automobile policies — both personal and commercial — which package property and casualty coverages together for the complete protection of the insured's "auto exposure."

First, we shall explore the Personal Auto Policy (P.A.P.) and its coverages in detail to provide the reader with a basic understanding of auto insurance. Then, we shall review briefly the various personal and commercial auto coverages available.

Personal Auto Policy (PAP)

Just as the Homeowners Program underwent revisions in recent years by the Insurance Services Office (ISO) to provide a more readable and understandable policy, personal auto insurance has evolved from the Family Auto Policy and Special Package Auto Policy to the *more readable* Personal Auto Policy (P.A.P.).

The P.A.P. is divided into seven separate sections as follows:

- Definitions;
- Part A — Liability coverage;
- Part B — Medical Payments coverage;
- Part C — Uninsured Motorist coverage;
- Part D — Coverage for Damage to Your Auto;
- Part E — Duties after an Accident or Loss;
- Part F — General Provisions.

Let's discuss these sections in detail, but first, we should note "the market" for a P.A.P.

P.A.P. Market

In general, four-wheel motor vehicles which are owned or leased (for a minimum period of six consecutive months) by an individual or married couple and their families for *personal use* can be covered under the P.A.P.

As a result, just about any private passenger auto, pickup or van is eligible for coverage under the P.A.P. although certain vehicles and certain vehicle use are specifically excluded from coverage under the underwriting program of individual companies.

Finally, the P.A.P. is designed for one's personal auto exposure, not commercial use.

With this background, let's proceed into the definitions section.

Definitions

The definitions section of the P.A.P. clearly defines the "who" and "what" of coverage.

The *insured* for contractual purposes — referred to as "you" and "your" throughout the policy — is considered to be:

- the insured named in the Declarations;
- his/her spouse.

Each coverage part defines the term "insured" for its own purposes.

A "family member" means a person related to the insured by blood, marriage or adoption who is a resident of the insured's household, including a ward or foster child.

The "covered auto" includes:

- any private passenger auto, pickup or van shown in the Declarations;
- any covered vehicle acquired during the policy period;
- any "trailer" the insured owns;
- any auto or "trailer" the named insured does not own while used as a temporary substitute for any other vehicle described in this definition which is out of normal use because of its:
  - breakdown;
  - repair;
  - servicing;
  - loss; or
  - destruction.

A "trailer" means a vehicle designed to be pulled by:

- a private passenger auto;
- pickup or van.

It can also mean a farm wagon or farm implement towed by a private passenger auto, pickup or van.

Part A — Liability Coverage

The P.A.P. liability coverage provides payment for B.I. and P.D. damages resulting from the insured's *use of an automobile.*

Under Part A, the company promises to settle or defend claims brought against the insured involving the insured's use of an auto. *In addition to* the limit of liability written for a particular policy, the company agrees to pay for all *defense costs.*

The P.A.P. is written on a *single limit basis*, one amount representing the aggregate limit for all claims arising from *any one accident.* As a result, a P.A.P. written for $100,000 would provide that total amount for all B.I. and P.D. claims arising out of one accident regardless of the number of:

- insureds;
- claims made;
- vehicles involved.

In contrast, some auto policies are written on a *split limit* basis for liability coverage such as 15/30/5. In this case, $15,000 is available as a maximum in any one accident for any one person; $30,000 as a maximum for all persons in any one accident; and $5,000 as a maximum for all property damaged in any one accident.

split limit . auto
50/100/25

Part A — Insureds

The following individuals are considered to be insureds under the *liability* coverage of the P.A.P.:

the insured ("you") or any "family member" for the ownership, maintenance or use of any auto or "trailer";

any person using "your covered auto" with permission;

any organization with respect to legal responsibility for acts or omissions of a person for whom coverage is afforded under this part.

First of all, the named insured or any family member (as previously defined) is covered for the ownership, maintenance or use of *any* auto or trailer. As a result, the insured's P.A.P. comes to the insured's liability protection in numerous instances.

Next, you can loan your car to many individuals with the confidence that your liability insurance extends to cover them while they are driving as well as covers you for this contingent liability exposure. If this driver were performing a task for or representing an organization, this organization would be covered as well.

For example, while acting as a volunteer coach for your town basketball league, you might be involved in an auto accident while driving your players home. In this event, the P.A.P. liability coverage would apply to your liability exposure as a driver and owner of the vehicle as well as any liability that may be held against the basketball league in this situation.

If you loaned your car to an assistant coach to take the players home, your P.A.P. liability coverage would apply to your liability exposure as owner of the auto, the assistant coach's exposure as a driver and the league's exposure in this situation.

Supplementary Payments

In addition to the limit of liability provided under Part A, the following supplementary payments are available:

Up to $250 for the cost of bail bonds required because of an accident. The accident must result in "bodily injury" or "property damage" covered under this policy.

Premiums on appeal bonds and bonds to release attachments in any suit the company defends.

Interest accruing after a judgment is entered in any suit the company defends.

Up to $50 a day for loss of earnings, but not other income, because of attendance at hearings or trials.

Other reasonable expenses incurred at the company's request.

Exclusions

The P.A.P. liability coverage does *not* apply to a person:

- who intentionally causes "bodily injury" or "property damage";
- for damage to property owned or being transported by that person;
- for damage to property:
  - rented to;
  - used by; or
  - in the care of;

  that person. This exclusions does not apply to damage to a residence or private garage.
- for "bodily injury" to an employee of that person during the course of employment. This exclusion does not apply to "bodily injury" to a domestic employee unless workers' compensation benefits are required or available for that domestic employee.
- for that person's liability arising out of the ownership or operation of a vehicle while it is being used to carry persons or property for a fee. This exclusion does not apply to a share-the-expense car pool.
- while employed or otherwise engaged in the "business" of:
  - selling;
  - repairing;
  - servicing;
  - storing; or
  - parking. vehicles designed for use mainly on public highways.

  This includes road testing and delivery.

  This exclusion does not apply to the ownership, maintenance or use of a "covered auto" by:
  - the named insured;
  - any "family member"; or
  - any partner, agent or employee of the named insured or any "family member."
- maintaining or using any vehicle while that person is employed or otherwise engaged in any "business" (other than farming or ranching). This exclusion does not apply to the maintenance or use of a:
  - private passenger auto;
  - pickup or van that the named insured owns; or
  - trailer used with one of these vehicles.
- using a vehicle without a reasonable belief that that person is entitled to do so.
- for "bodily injury" or "property damage" for which that person:
  - is an insured under a nuclear energy liability policy; or
  - would be an insured under a nuclear energy liability policy but for its termination upon exhaustion of its limit of liability.

A nuclear energy liability policy is a policy issued by any of the following or their successors:

- American Nuclear Insurers;
- Mutual Atomic Energy Liability Underwriters; or
- Nuclear Insurance Association of Canada.

In like manner, liability for the ownership, maintenance and use of the following vehicles is specifically *excluded*:

- any motorized vehicle having fewer than four wheels;
- any vehicle, other than "the covered auto," which is:
  - owned by the named insured; or
  - furnished or available for the named insured's regular use.
- any vehicle, other than "your covered auto," which is:
  - owned by any "family member;" or
  - furnished or available for the regular use of any "family member."

However, this exclusion does not apply to your maintenance or use of any vehicle which is:

- owned by a "family member;" or
- furnished or available for the regular use of a "family member."

Out of State Coverage

If the insured becomes involved in an auto accident out of state and the state involved requires higher liability limits than the insured maintains, the P.A.P. will provide the higher specified limit for this accident.

Similarly, some states require non-residents to maintain certain insurance limits whenever they operate an auto in that state. The P.A.P. will provide at least these required minimum amounts in response.

Part B — Medical Payments

Under Part B, the company agrees to pay for "reasonable expenses incurred for necessary medical and funeral services because of bodily injury":

- caused by accident; and
- sustained by an "insured."

"Insured" is defined as:

- the named insured or family member while occupying a motor vehicle designed for use mainly on public roads or a trailer of any type;
- the named insured or family member hit by an auto while a pedestrian;
- any other person while occupying the insured covered auto.

Unlike the medical payments coverage of the Homeowners Program, automobile medical payments is specifically designed to cover medical expenses *incurred by the insured*. The time limit for incurring medical expenses is usually *three years* with newer policies.

Finally, medical expenses coverage responds on a per person, per accident basis regardless of the number of:

- insureds;
- claims made;
- vehicles involved.

Any amounts payable under medical payments coverage will be reduced by any amounts payable under Liability (Part A) or Uninsured Motorist (Part C) coverage.

Exclusions

Medical Payments coverage does *not* apply to any persons for bodily injury:

- sustained while "occupying any motorized vehicle having fewer than four wheels;
- sustained while "occupying" "your covered auto" when it is being used to carry persons or property for a fee. This exclusions does not apply to a share-the-expense car pool;
- sustained while "occupying" any vehicle located for use as a residence or premises;
- occurring during the course of employment if workers' compensation benefits are required or available for the "bodily injury";
- sustained while "occupying," or when struck by, any vehicle (other than "your covered auto") which is:
  - owned by you; or
  - furnished or available for your regular use.
- sustained while "occupying," or when struck by, any vehicle (other than "your covered auto") which is:
  - owned by any "family member;" or
  - furnished or available for the regular use of any "family member." However, this exclusion does not apply to the named insured.
- sustained while "occupying" a vehicle without a reasonable belief that that person is entitled to do so.
- sustained while "occupying" a vehicle when it is being used in the "business" of an "insured." This exclusion does not apply to "bodily injury" sustained while "occupying" a:
  - private passenger auto;
  - pickup or van that you own; or
  - "trailer" used with a vehicle described above.
- caused by or as a consequence of:
  - discharge of a nuclear weapon (even if accidental);
  - war (declared or undeclared);
  - civil war;
  - insurrection; or
  - rebellion or revolution.
- from or as a consequence of the following, whether controlled or uncontrolled or however caused:
  - nuclear reaction;
  - radiation; or
  - radioactive contamination.

AUTOMOBILE INSURANCE

P.A.P. UNINSURED MOTORIST and PHYSICAL DAMAGE

Preview

Part C — Uninsured Motorist (U.M.) Coverage — protects the insured and occupants of the insured vehicle against B.I. resulting from an auto accident with:

- uninsured motorists;
- "insureds" carrying less than financial responsibility amount;
- hit and run drivers.

Part D — Coverage for Damage to Your Auto:

- *Collision* — collision and upset;
- *Comprehensive* — other than collision, such as:
  - — fire;
  - — theft;
  - — vandalism;
  - — animals;
  - — glass breakage.

AUTOMOBILE INSURANCE
UNINSURED MOTORIST and PHYSICAL DAMAGE

Part C — Uninsured Motorist Coverage

Under Part C, the Uninsured Motorist (U.M.) Coverage agrees to pay "damages which an insured is legally entitled to recover from the owner or operator of an uninsured motor vehicle because of bodily injury sustained in an auto accident." What does this mean? Consider the following accident.

You're driving north on Main Street when a car traveling west on Broad Street runs a red light, hits you broadside, pushes you into a parked car and takes off. This "hit and run" driver, as we shall see, falls within the definition of uninsured motorist. As such, *you* as the insured under a P.A.P. could collect from *your company* under Part C damages for bodily injury that you would be entitled to receive from the "hit and run" driver if he had insurance.

As always, the definitions of coverage (in this case, "insured" and "uninsured" motor vehicle) play a key role.

Insured

An "insured" under Uninsured Motorists coverage includes:

- the named insured or any "family member" while occupying a motor vehicle or struck as a pedestrian;
- any other person occupying the covered auto;
- any person for damages that person is entitled to recover because of "bodily injury" to which this coverage applies sustained by a person described above (such as a spouse or parent of an individual killed in an accident).

Uninsured Motor Vehicle

"Uninsured motor vehicle" means a land motor vehicle or trailer of any type:

- to which no bodily injury liability bond or policy applies at the time of the accident;
- to which a bodily injury liability bond or policy applies at the time of the accident, *less than the minimum limit for bodily injury liability specified by the financial responsibility law* of the state in which your covered auto is principally garaged;
- which is a "hit and run" vehicle whose operator or owner cannot be identified;
- to which a bodily injury liability bond or policy applies at the time of the accident, but the bonding or insuring company:
  - — denies coverage; or
  - — is or becomes insolvent.

However, "uninsured motor vehicle" does *not* include any vehicle or equipment:

- owned by or furnished or available for the regular use of you or any "family member";

- owned or operated by a *self-insurer* under any applicable motor vehicle law;
- owned by any governmental unit or agency;
- operated on rails or crawler treads;
- designed mainly for use off public roads while not on public roads;
- while located for use as a residence or premises.

Exclusions

Having defined who an insured is and what an uninsured motor vehicle is, U.M. coverage describes those situations which are *excluded* from coverage:

- while occupying, or when struck by, any motor vehicle owned by the named insured or any family member which is not insured for this coverage under this policy. This includes a trailer of any type used with that vehicle;
- if that person or the legal representative settles the "bodily injury" claim without the company's consent;
- while occupying your covered auto when it is being used to carry persons or property for a fee. This exclusion does not apply to a share-the-expense car pool;
- using a vehicle without a reasonable belief that that person is entitled to do so.

This coverage will not apply directly or indirectly to benefit any insurer or self-insurer under any of the following or similar laws:

- workers' compensation law; or
- disability benefits law.

Arbitration

As noted, U.M. coverage enables the named insured, resident family members and passengers in a covered auto to collect *from the insured's policy* sums another driver would be legally liable to pay for B.I. As a result, under U.M. coverage, the insurer and insured assume an adversarial relationship of sorts.

The insured submits a claim under U.M. coverage as if he were a third party claimant seeking reimbursement for medical expenses and other out-of-pocket specials such as lost wages as well as compensation for "pain and suffering." Since this latter amount is very subjective, U.M. coverage anticipates certain differences of opinion between insurer and insured and addresses this contingency by inserting an arbitration clause.

Specifically, if the insurer and insured do *not* agree on whether or not a U.M. claim is covered or, if covered, for how much, either party may demand arbitration.

The arbitration process under U.M. is similar to that of the property contracts:

- each party (insurer and insured) seeks an arbitrator to represent them;
- the two arbitrators select a third;
- if the two arbitrators cannot agree on the third arbitrator, a judge of a local court will make the decision.

A decision of two of the three arbitrators is binding.

Underinsured Motorist Coverage

Underinsured Motorist Coverage, available by endorsement under the P.A.P., covers the insured when involved in a collision with a driver who has insurance, but the limit of this insurance is insufficient to pay for the *insured's damage.*

As with U.M. coverage, Underinsured Motorist coverage enables the insured to collect from the *insured's own policy* sums another driver is legally liable to pay for B.I. Under U.M., by definition, the responsible driver has no insurance and, as a result, the insured's policy must respond for the total amount. Under Underinsured Motorist coverage, by definition, the responsible driver has *insufficient* insurance to address the insured's claim and, as a result, the insured's policy must respond for the *difference* between the insured's damages and the responsible party's liability limits.

For example, assume the insured's B.I. claim resulting from an auto accident is worth $60,000 and the responsible party carries only $15,000 in coverage. If the insured carried $60,000 or more in Underinsured Motorist coverage, he would receive $15,000 from the responsible party and $45,000 from his Underinsured Motorist coverage. If he carried less than $60,000 in Underinsured Motorist coverage (say $50,000), he would receive the difference between this limit and the $15,000 of the responsible party ($35,000 in this case).

It is extremely important that the insured carry sufficient U.M. coverage to address this critical need.

Part D — Coverage for Damage to Your Auto

Part D — Coverage for Damage to Your Auto (formerly known as Physical Damage coverage) is divided into two separate coverages which apply to *the insured's auto:*

- collision;
- comprehensive.

"Collision" means the *upset* of a covered auto or its *impact* with another vehicle or object. Examples of collision include:

- the insured, traveling at a high speed around a sharp curve, turns over;
- the insured loses control of his car and crashes into a pole;
- the insured, stopped at a light, gets hit in the rear.

Obviously, *collision coverage* addresses collisions; *comprehensive coverage* addresses property damage losses to the insured vehicle involving losses "other than collisions" which include losses caused by:

- missiles or falling objects;
- fire;
- theft or larceny;
- explosion or earthquake;
- windstorm;
- hail, water or flood;
- malicious mischief or vandalism;
- riot or civil commotion;
- contact with bird or animal; or
- breakage of glass.

If breakage of glass is caused by a "collision," the insured may elect to consider it a collision loss.

Under Part D, the company agrees to pay for "direct and accidental loss to the insured's covered auto or any non- owned auto," including their equipment, minus any applicable deductible. Non-owned autos are covered on an excess basis.

"Non-owned auto" means any private passenger auto, pickup, van or "trailer" not owned by or furnished or available for the regular use of the insured or any family member while in the custody of or being operated by the insured or any family member.

However, "non-owned auto" does not include any vehicle used as a temporary substitute for a vehicle the insured owns which is out of normal use because of its:

- breakdown;
- repair;
- servicing;
- loss; or
- destruction.

Transportation Expenses

In addition, the insurer will pay up to $10 per day, to a maximum of $300, for transportation expenses incurred by the insured. This applies only in the event of the total theft of your covered auto. The insurer will pay only transportation expenses incurred during the period:

- beginning 48 hours after the theft; and
- ending when your covered auto is returned to use or we pay for its loss.

Exclusions

Under Part D — Coverage for Damage to Your Auto, the insurer will *not* pay for:

- loss to the "covered auto" which occurs while it is used to carry persons or property for a fee. This exclusion does not apply to a share-the-expense car pool;
- damage due and confined to:
  - wear and tear;
  - freezing;
  - mechanical or electrical breakdown or failure; or
  - road damage to tires. This exclusion does not apply if the damage results from the total theft of your covered auto.
- loss due to or as a consequence of:
  - radioactive contamination;
  - discharge of any nuclear weapon (even if accidental);
  - war (declared or undeclared);
  - civil war;
  - insurrection; or
  - rebellion or revolution.

loss to equipment designed for the reproduction of sound. This exclusion does not apply if the equipment is permanently installed;

loss to tapes, records or other devices for use with equipment designed for the reproduction of sound;

- loss to a camper body or "trailer" you own which is not shown in the Declarations. This exclusion does not apply to a camper body or trailer you:
  - acquire during the policy period; and
  - ask us to insure within 30 days after you become the owner.
- loss to any "non-owned" auto or any vehicle used as a temporary substitute for a vehicle the insured owns, when used by the insured or any family member without a reasonable belief that the insured or that family member are entitled to do so;
- loss to:

  TV antennas;
  - awnings or cabanas; or
  - equipment designed to create additional living facilities.

  loss to any of the following or their accessories:

  citizens band radio;

  two-way mobile radio;

  telephone; or
  - scanning monitor receiver.

  This exclusion does not apply if the equipment is permanently installed.
- loss to any custom furnishings or equipment in or upon any pickup or van. Custom furnishings or equipment include but are not limited to:
  - special carpeting and insulation, furniture, bars, or television receivers;
  - facilities for cooking and sleeping;
  - height-extending roofs; or
  - custom murals, paintings or other decals or graphics.
- loss to equipment designed or used for the detection or location of radar;
- loss to any non-owned auto being maintained or used by any person while employed or otherwise engaged in the "business" of:

  selling;

  repairing;

  servicing;
  - storing; or
  - parking vehicles designed for use on public highways. This includes road testing and delivery.

Limit of Liability

The company's limit of liability for a collision or comprehensive loss will be the lesser of the:

- actual cash value of the stolen or damaged property; or
- amount necessary to repair or replace the property.

However, the most the company will pay for the loss to any non-owned trailer is $500.

An adjustment for depreciation and physical condition will be made in determining actual cash value at the time of loss.

A person seeking coverage for Damage to Your Auto must also:

- take reasonable steps after loss to protect your covered auto and its equipment from further loss;
- promptly notify the police if your coverd auto is stolen;
- permit the company to inspect and appraise the damaged property before its repair or disposal.

General Provisions

Policy Period and Territory

This policy applies only to accidents and losses which occur:

- during the policy period as shown in the Declarations; and
- within the policy territory.

The policy territory is:

- the United States of America, its territories or possessions;
- Puerto Rico; or
- Canada.

This policy also applies to loss to, or accidents involving, your covered auto while being transported between their ports.

Cancellation

This policy may be cancelled during the policy period as follows:

- the named insured shown in the Declarations may cancel by:
  - returning this policy to the company; or
  - giving the company advance written notice of the date cancellation is to take effect.
- the company may cancel by mailing to the named insured shown in the Declarations at the address shown in this policy:
  - at least 10 days notice:
    - if cancellation is for nonpayment of premium; or
    - if notice is mailed during the first 60 days this policy is in effect and this is not a renewal or continuation policy; or
  - at least 20 days notice in all other cases.
- after this policy is *in effect for 60 days*, or if this is a renewal or continuation policy, the company will cancel only:

for nonpayment of premium; or

if named insured's driver's license or that of:

any driver who lives with him; or

any driver who customarily uses his covered auto
is suspended or revoked.

Nonrenewal

If the company decides not to renew or continue this policy, it will mail notice to the named insured shown in the Declarations at the address shown in this policy. Notice will be mailed at least 20 days before the end of the policy period.

If the policy period is other than 1 year, the company will have the right not to renew or continue it only at each anniversary of its original effective date.

Note: cancellation and nonrenewal requirements are *subject to state approval.*

Subrogation

If the company makes a payment under the P.A.P. and the person receiving payment has a right of action against another party, the company will assume that right and proceed against the other party.

For example, consider the situation in which an insured is hit in the rear while stopped at a light. This accident was the fault of the "other driver." If the insured collected under his collision coverage for the damage, the insurance company would then assume the insured's right of recovery against the responsible party and subrogate.

Through the subrogation process, the company would attempt to recover all the monies it paid its insured as well as any deductible the insured might have covered. Deductibles are returned to insureds to make them whole.

Conclusion

The P.A.P. is the latest in a long line of package policies designed to cover the various risks associated with the personal use of an automobile.

It protects insureds against the liability they may incur for injuring others or damaging their property (B.I. and P.D. liability) due to the use of the insured car.

It covers insureds for medical bills they may sustain (Medical Payments) due to auto accidents.

It protects insures against B.I. losses caused by uninsured (U.M. coverage) or underinsured (Underinsured Motorist coverage).

And it protects insureds against loss sustained to their automobiles due to contact or upset with another vehicle on the road itself (Collision) and loss due to other means (Comprehensive).

Commercial Auto Insurance

Just as the P.A.P. is designed to address an insured's *personal* automobile risk exposures, there are a number of commercial policies available to address the *commercial* automobile risk exposures.

Commercial automobiles and vehicles registered in the names of businesses can be written under one of several forms:

- Business Auto Policy;
- Truckers Policy;

- Garage Policy;
- Comprehensive Auto Liability Policy.

Business Auto Policy

The Business Auto Policy provides selected liability and physical damage coverages for business risks under an easy-to-read contract. The policy is divided into five sections:

- Section I — Covered Autos;
- Section II — Liability coverage;
- Section III — Physical Damage coverage;
- Section IV — Conditions;
- Section V — Definitions.

The Business Auto Policy coverage only applies to covered autos as defined in Section I (by nine symbols or types of autos) and listed in the policy Declarations. The Business Auto Policy may insure all types of trucks, semi- trailers, commercial vehicles used on public roadways in addition to private passenger autos.

As a result, a Business Auto Policy may be used to insure a construction company that owns cement mixers, tractor-trailers used to transport heavy equipment, pickup trucks, vans and private passenger autos used by management and labor.

Truckers Policy

A "trucker" is defined as any person or organization engaged in the business of transporting property by auto for hire. The Truckers Policy is geared to meet the specialized needs of persons and organizations involved in the trucking industry as witnessed by the "extra" section to its form:

- Section I — Covered Autos;
- Section II — Liability coverage;
- Section III — Trailer Interchange coverage;
- Section IV — Physical Damage coverage;
- Section V — Conditions;
- Section VI — Definitions.

As can be seen, the Truckers Policy provides the same coverages as the Business Auto Policy, but adds a "trailer interchange" coverage.

"Trailer interchange" coverage provides coverage for an insured trucker when required to reimburse another trucker for damage to the other's owned trailer while in the insured's possession.

For example, many truckers are "owner-operators" who own their own tractors and offer their services to haul non- owned trailers full of goods from one place to another. While these non-owned trailers are in the insured trucker's possession, these truckers will be covered for other resultant liability under the Trailer Interchange coverage.

Garage Policy

The Garage Policy is designed to address the specialized needs of two classes of risk:

- automobiles dealers;
- automobile service organizations, such as service stations, storage garages and public parking places.

This policy is divided into six sections, the unique one being the third:

- Section I — Covered Autos;
- Section II — Liability coverage;
- Section III — Garagekeepers coverage;
- Section IV — Physical Damage coverage;
- Section V — Conditions;
- Section VI — Definitions.

Under Section II — Liability coverage, property damage to autos in the insured's care, custody and control is *excluded*. Under Section III — Garagekeepers coverage, it specifically is *covered*. Section II is designed to cover the insured's liability for the use of owned cars or cars in the insured's possession, but not damage to the latter. Section III covers that exposure.

For example, Joe's Gas Station is insured under a Garage Policy. When returning from a tow call, Joe accidentally hits a car receiving gas at one of his pumps with the rear of the car that he was towing. Section II — Liability coverage would address the damage to the car receiving gas and any injuries sustained by any of its occupants. Section III — Garagekeepers coverage would address the damage to the car being towed because it is in the insured's care, custody and control.

Comprehensive Auto Liability Policy

The Comprehensive Auto Liability Policy provides *auto liability insurance for businesses* on a broad basis.

The insured is covered for occurrences arising out of the ownership, maintenance or use of automobiles, either owned, hired or non-owned.

Any commercial or manufacturing enterprise in whose name a number of vehicles are registered and in whose interest other vehicles are used is a prospect for Comprehensive Automobile Liability insurance.

HOMEOWNERS INSURANCE

THE HOMEOWNERS PROGRAM

Introduction

Prior to World War II, property insurers and casualty insurers were separate entities. If an individual wanted a property policy, such as dwelling coverage, he went to a property insurer. If he wanted a casualty policy, such as personal liability coverage, he went to a casualty insurer. At best, much time was wasted. At worst, many individuals went uninsured or inadequately insured. Fortunately, today, the emphasis is toward multiline insurers and multiline contracts.

The Homeowners Program was one of the original products of the concept of "multilining" or "packaging" policies to afford more comprehensive coverage than would be available under separate, individual policies. Basically, the Homeowners Program provides the property coverages available under the Dwelling Property Program with theft insurance and personal liability coverage under one contract. Why is this "packaging" of contracts so important?

Package policies offer a single contract with a single expiration date and common policy conditions that provide more comprehensive protection than could be obtained by purchasing a number of contracts from different agents and/or insurers. The savings in processing alone is significant and it is passed on to the consumer.

If the Homeowners Program offers such comprehensive coverage, then why would anyone purchase a Dwelling Property policy? Some possible reasons include:

- price (the Dwelling Program might offer a cheaper buy);
- need (a particular individual might not need the comprehensive coverage offered under the Homeowners Program);
- eligibility (more often than not, an individual would purchase a Dwelling Property Policy because he is not eligible for the Homeowners Program).

Eligibility

The following types of *personal* residences/occupancies and/or their contents are eligible for coverage under the Homeowners Program:

- *Owner-occupants of residential dwellings* which do *not* contain more than two families nor more than two boarders or roomers per family are eligible for the *dwelling and contents* coverage provided by the Homeowner forms HO-1, HO-2, HO-3, HO-5 and HO-8 (or any modification of these forms).
- *Tenants* in nonowned (by them) buildings used primarily for *residential purposes* are eligible for *contents coverage* under the HO-4 (apartment dwellers coverage).
- *Owner-occupants of condominiums* are eligible for coverage for their *interest in the condominium* as well as *contents* under the HO-6.

The majority of Homeowenrs Policies are sold to owner occupants of one-family homes who have an obvious insurable interest in their residential premises and contents; however, the following individuals are eligible for dwelling and contents coverage under the Homeowners Program due to their *insurable interests*:

- individuals who purchase homes under installment contracts with their builders and occupy the homes as they pay off the loan;
- individuals who occupy dwellings under a life estate arrangement and maintain Dwelling Coverage in an amount at least equal to 80% of the dwelling's replacement cost;
- individuals who own homes under the course of construction;
- a co-owner of a two-family house which has clearly delineated halves;

- joint-owners of a dwelling who are non-occupants;
- owners of seasonal dwellings who are insured under a Homeowners Policy for their primary dwelling.

Overview

The Homeowners Program has been modified steadily in recent times to provide consumers with more readable policies that address the changing needs of society. Beginning in 1976, then again in 1982 and 1984, the Insurance Service Office (ISO) modified its policy offerings as much in response to the courts as consumers. As a result, there are some differences among the various forms. Since different states use different versions of the Homeowners forms, we shall provide a general, conceptual treatment of the Homeowners Program in this textbook in keeping with its academic purpose.

In general, the Homeowners Program consists of six different forms, each providing six basic coverages.

The six Homeowners forms are:

- HO-1* Basic;
- HO-2 Broad;
- HO-3 Special;
- HO-4 Tenant Broad;
- HO-5* Comprehensive;
- HO-6 Condominium.

**Note:*

- HO-1: This form has been discontinued in many states and replaced with an HO-8 which will be discussed.
- HO-5: This form has been eliminated in newer programs. The coverage it provided is now obtained through the use of an HO-3 and a special endorsement.

The HO-1, HO-2, HO-3 and HO-5 (as well as HO-8) were designed to address the personal insurance exposures resulting from the onwer-occupancy of residential dwellings and the resultant use of personal property. As a result, each of these forms provides coverage for the following property and/or losses:

Section I Coverages

- Coverage A — Dwelling;
- Coverage B — Other Structures;
- Coverage C — Personal Property;
- Coverage D — Loss of Use.

Section II Coverages

- Coverage E — Personal Liability;
- Coverage F — Medical Payments to Others.

From a glance, you will note that the Section I Coverages sound familiarly close to the Dwelling Property Coverages and, as we shall soon see, they are. Section II Coverages "package" two important casualty coverages with the four property coverages to address the personal liability exposures of a home owner. These Section II Coverages, along with the added protection of theft coverage, make the Homeowners Program much more comprehensive in scope than the Dwelling Property Program.

The HO-4 is designed to insure tenants in residences which they do *not* own. As a result, no Coverage A (Dwelling) nor Coverage B (Other Structures) is needed nor provided under the HO-4.

Similarly, the HO-6 is designed for the owners of condominiums, structures which are owned by condominium associations not individuals per se. As a result, no Coverage A nor Coverage B is provided under the HO-6. An insured condominium owner's interest in the condominium complex as a whole as well as other important exposures is addressed in a comprehensive endorsement to the HO-6.

As with the Dwelling Property Program, the Homeowners forms basically differ in the perils they provide under Section I coverages. Section II liability coverage is exactly the same under all forms.

The *HO-1* provides coverage for direct physical loss caused by:

- fire;
- lightning;
- E. C. Perils:

windstorm;	(W)
civil commotion;	(C)
smoke;	(S)
hail;	(H)
aircraft;	(A)
vehicles;	(V)
explosion;	(E)
riot;	(R)

- vandalism and malicious mischief (VMM);
- glass breakage;
- theft;
- volcanic eruption.

Theft includes "attempted theft" and "loss of property from a known place when it is likely that the property has been stolen."

The theft peril does *not* include loss caused by theft:

- committed by the insured;
- from a dwelling under construction;
- from a part of the residence rented to other than an insured;
- of watercraft, including its furnishings, away from the insured premises;
- of trailers and campers away from the insured premises;
- of property from a residence owned by, rented to or occupied by an insured unless the insured is temporarily living there.

The *HO-2* provides coverage for direct physical loss caused by:

- the BASIC HO-1 perils, two of which (smoke and vehicle damage) are broadened under the HO-2 as they are under the DP-2;

- the "Broad Form perils":

burglar damage;	(B)
ice and snow;	(I)
glass breakage (no dollar limit);	(G)
accidental discharge;	(A)
falling objects;	(F)
freezing of pipes;	(F)
electrical damage;	(E)
collapse (technically, an additional coverage);	(C)
tearing asunder.	(T)

The *HO-3* provides coverage for direct physical loss caused by:

- all risk — dwelling;
- HO-2 Broad perils — contents.

The *HO-5* provides coverage for direct physical loss caused by:

- all risk — dwelling;
- all risk — contents.

In recent years, the HO-5 has fallen out of favor and has been discontinued all together in recent policy modifications. In place of the HO-5, the HO-3 is used along with the Special Personal Property Coverage endorsement (HO-15) to effect the same all risk coverage.

The *HO-4* and *HO-6* essentially provide the same Broad Form perils coverage with few exceptions. Since the HO-4 is designed for tenants of apartments who are *not* owner- occupants, the HO-4 provides extensive coverage on the insured's contents and provides the comprehensive liability coverage of Section II.

The HO-6 provides this same Broad Form coverage on the insured's contents and comprehensive liability coverage of Section I as well as addresses the special needs of condominium owners by offering comprehensive endorsements to the basic policy. It also provides broader Additions and Alterations Coverage.

For example, the insured's exposure to loss as a member of the condominium association can be insured under the HO-6.

Finally, the *HO-8* is a modification of the HO-1, designed primarily for dwelling owners living in areas where home market values are far below the replacement cost of the dwelling. As you know, "market value" is the actual cost of a home ("the going rate") in a given area; usually, the more prestigious the area, the higher the cost of the home. "Replacement cost" refers to the actual cost a builder will charge to build a structure on a given piece of land owned by the insured.

The most significant difference between the HO-1 and the HO-8 is that the former is written on a replacement cost basis; the latter, actual cash value.

Conclusion

As we have seen, the Homeowner Program provides a much more comprehensive group of policies than offered under the Dwelling Property Program: the former packages a number of individual property and casualty coverages under one policy to address just about every risk exposure of the home owner.

We shall now review the actual coverages of the Homeowners Program.

THE HOMEOWNERS PROGRAM

Coverages

Preview

Homeowners Coverages:

Section I — Property

- *Coverage A* — Dwelling;
- *Coverage B* — Other Structures;
- *Coverage C* — Personal Property;
- *Coverage D* — Loss of Use.

Section II — Liability

- *Coverage E* — Personal Liability;
- *Coverage F* — Medical Payments to Others.

HOMEOWNERS PROGRAM COVERAGES

As noted, each of the Homeowners Policies provides coverage for the following property and/or losses:

Section I — Property

- Coverage A — Dwelling;
- Coverage B — Other Structures;
- Coverage C — Personal Property;
- Coverage D — Loss of Use.

Section II — Liability

- Coverage E — Personal Liability;
- Coverage F — Medical Payments to Others.

Unlike the Dwelling Property Program, the Homeowners coverages are offered on a package basis for owner-occupants of dwellings employing the HO-1, HO-2, HO-3 or HO-5. In other words, if the policies are purchased, the insured *automatically* receives the four property and two liability coverages. In contrast, under the Dwelling Property Program, the insured could purchase coverage on the dwelling only or contents only or both dwelling and contents.

Because of the nature or focus of coverage, the HO-4 and HO-6 do *not* provide Coverage A - Dwelling nor Coverage B - Other Structures.

SECTION I — PROPERTY

Coverage A — Dwelling

As with the Dwelling Property forms, the "dwelling" in the Homeowners Program covers:

- the dwelling described on the Dec Page;
- structures attached to this dwelling;
- materials and supplies located on the dwelling used for construction, alteration or repair of the dwelling.

Coverage B — Other Structures

Coverage B applies to structures located on the insured premises which are separated from the dwelling (the subject of Coverage A) by a clear space or connected only by a fence, utility line or similar connection. As a result, attached garages are part of the structure and covered under Coverage A.

Structures used for business purposes are *not* covered nor are those rented to a non-tenant; however, garages used as private garages are covered even if rented to a non-tenant.

Under Coverage B, 10% of the amount of insurance written under Coverage A is provided for Coverage B as an *additional amount of insurance*. For example, a Homeowners policy with $100,000 Coverage A would provide $10,000 on Coverage B automatically.

Coverage C — Personal Property

Coverage C — Personal Property provides broader coverage under the Homeowners Program than under the Dwelling Property Program.

Under the Homeowners Program, the full limit of Coverage C (not just 10% as with the Dwelling Program) applies to personal property *anywhere in the world.*

Under the HO-1, HO-2, HO-3, HO-5 and HO-8, *50% of the amount of insurance written on Coverage A applies* to Coverage C. As a result, the dwelling written with a $100,000 Coverage A amount will automatically have $50,000 or 50% of Coverage A as its Coverage C amount as an *additional amount of insurance.*

At the request of the named insured, the following personal property can be covered under the insured's Coverage C amount:

- personal property of others while it is located at the insured's premises;
- personal property of a guest or residence employee at a residence occupied by an insured.

Coverage for personal property usually kept at an insured's residence other than the residence premises (such as a summer bungalow) is covered for the larger of $1,000 or 10% of Coverage C.

Personal property moved to a *newly acquired* principal residence is exempt from this 10% limitation for the first *30 days* after the move.

The Homeowners Program *excludes* certain types of personal property under Coverage C:

- animals, birds and fish;
- automobiles and other motorized vehicles (except vehicles pertaining to the service of the premises);
- any device or instrument for transmitting, recording, receiving or reproducing sound or any tape or record used with such device *while* in a motor vehicle;
- aircraft and parts;
- property of roomers/boarders *not* related to the insured;
- property regularly located in a rental of the insured while away from premises;
- business property carried or held as samples for delivery after a sale;
- business property of a business located on the insured premises;
- business property while away from the insured premises;
- property *scheduled* elsewhere.

Coverage C provides certain *internal limits* on categories of property per occurrence, such as:

- money, bank notes, bullion, gold and silver;
- securities, accounts, deeds, evidences of debt, letters of credit, etc.;
- watercraft, including their trailers, furnishings, etc.;
- trailers not used with watercraft;
- grave markers;
- theft of jewelry, watches, furs, precious and semiprecious stones;
- theft of pewterware, goldware and silverware;
- theft of firearms.

Specific dollar limits apply to each of these categories of property. These dollar amounts differ with the edition of the Homeowners Program used. The important things to remember are that internal limits do exist on certain categories of personal property and these limits can be raised by endorsement if needed.

Finally, property scheduled (listed and insured with a *specific* amount of insurance) under another policy or an endorsement to a given Homeowners Policy will *not* be covered under Coverage C of that Homeowners Policy. Insureds cannot be reimbursed twice for the same loss.

Coverage D Loss of Use

This Homeowners Program coverage combines the reimbursement aspects of two separate Dwelling Property Program coverages:

- additional living expense;
- fair rental value.

If a covered peril renders the insured premises uninhabitable, this coverage will pay *either* the additional costs related to living elsewhere *or* the fair rental value of the insured premises minus non-continuing expenses.

As with the Dwelling Property Program, payments are made for the shortest time required to repair or replace the damaged property or until the insured settles into a new residence.

Finally, in order for this coverage to apply, the covered loss must have occurred during the policy period as might be expected; however, this coverage can continue in effect even if the policy has expired as long as the necessary repairs, etc. are in process.

Coverage D limits are written as a percentage of Coverage A under the HO-1, HO-2, HO-3 and HO-5 and a percentage of Coverage C under the HO-4 and HO-6 as follows:

HO-Form	% Amount	Of Coverage
HO-1	10%	A
HO-2	20%	A
HO-3	20%	A
tenant < HO-4	20%	C
HO-5	20%	A
condo < HO-6	40%	C

SECTION II LIABILITY

Under Section II — Liability portion of the Homeowners Program, the insured is covered for his responsibility as a home owner to the general public through the following coverages:

- Coverage E — Personal Liability;
- Coverage F — Medical Payments to Others.

We shall thoroughly review the whole subject of liability under the Casualty Section of this textbook. For now, we shall highlight the Homeowners Program Section II coverages.

Coverage E — Personal Liability

Coverage E pays, "on behalf of the insured, all sums which the insured becomes legally obligated to pay as damages because of bodily injury or property damage, to which insurance applies, caused by an occurrence." To understand this coverage in its entirety, we shall review it in its parts.

"On behalf of the insured" simply means that liability coverage is "third party coverage" and, as such, payments under the policy are made *directly* to "third parties" or individuals who are *not* actually one of the parties to the two-party insurance contract. For example, Jones falls on Smith's cracked sidewalk. Smith's Coverage E would address Jones' injury claim and pay Jones *directly* if required.

"All sums which the insured becomes liable to pay as damages" is intended to be vague enough to encompass specific losses or "specials" of a third party which would include doctors' bills, hospital bills, bills for damaged property and other specific amounts of money/damages lost by a third party in a particular occurrence as well as a dollar amount for "pain and suffering" and "inconvenience. Of course, insurance policy payments must be governed by policy limits.

"Because of bodily injury or property damage to which insurance applies" is a clause with a wealth of information." Bodily injury" refers to bodily harm, sickness and disease, including death. "Property damage" refers to physical injury to or destruction of tangible property, including loss of use. "To which insurance applies" means, under this policy, homeowners' liability exposures. Under an automobile policy, the exposure would be the auto exposure.

Finally, as previously noted, an "occurrence" is defined as an accident, including injurious exposure to conditions, which result in bodily injury or property damage during the policy.

Coverage E covers insureds for all non-business, legal liability arising out of:

an insured location (the insured premises as well as any location the insured occasionally rents, such as a hall for a wedding);

personal activities (sports, social, etc.);

- acts of residence employees acting within the scope of their employment.

Coverage E provides two separate coverages:

- Bodily Injury (B.I.) Liability;
- Property Damage (P.D.) Liability.

Let's return to our example of Jones falling on Smith's cracked sidewalk. If Smith were deemed negligent or responsible for Jones' fall by not properly maintaining a safe sidewalk, Smith's Homeowners Coverage E would pay for Jones' medical bills, lost wages and "pain and suffering" under the Bodily Injury (B.I.) Liability coverage. In contrast, Jones' torn pants and the radio he was carrying and fell on would be covered under the Property Damage (P.D.) Liability coverage.

In addition to paying for damages which the insured is legally liable, Coverage E will provide a legal defense at the insurer's choice, "even if the suit is groundless, false or fraudulent."

In this regard, the insurer may investigage and settle any claim or suit as it deems is appropriate. The insurer's duty to settle or defend ends when the amount the insurer pays a third party equals the policy limits.

Coverage F — Medical Payments to Others

Coverage F has been characterized as a "no-fault" or "good neighbor" coverage in that it pays third parties for their medical bills regardless of fault or liability.

Returning to our friends Smith and Jones, we would find Jones being reimbursed for the medical bills pertaining to the broken ankle sustained on Smith's premises even if the sidewalk had not been cracked or negligently maintained. In fact, Jones might have just tripped over his own feet and fell, breaking his ankle. Nonetheless, Smith's Coverage F would apply since the accident occurred on Smith's premises.

Of course, Coverage F is *not* limitless. It will pay for:

- *medical expenses only;* medical and surgical care; x-rays; dental services; ambulance, hospital and professional services; prosthetic devices; even funeral services — but not lost wages or "pain and suffering," etc.;
- covered expenses *incurred within three years* of the date of the *accident*;

guests and other individuals, but *not* the insured and regular residents of the household other than residence employees;

- up to the policy limits for this coverage (usually $1,000).

Coverage F applies to *others* (not insureds or regular residents) when they are:

- on the insured premises with the permission of the insured (either expressed or implied); or
- off the insured premises, if the bodily injury was caused by:
  - — a condition on the insured premises;
  - — an activity of the insured;
  - — a residence employee;
  - — an animal owned by the insured.

Liability and medical payments coverages will be discussed in detail in the casualty section. At this point, be aware of their roles in the Homeowners Program.

In the newer Homeowners forms, Coverage E is written for a minimum of $100,000; Coverage F, $1,000.

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THE HOMEOWNERS PROGRAM

Section I — Detailed

Preview

Additional Coverages:

- Debris Removal;
- Reasonable Repairs;
- Trees, Shrubs and Plants;
- Fire Department Service Charge;
- Property Removed;
- Credit Card Forgery;
- Loss Assessment;
- Collapse (not under HO-1);
- Building Additions and Alterations (HO-4 only).

Exclusions:

- Ordinance of Law;
- Earth Movement;
- Water Damage;
- Power Failure;
- Neglect;
- War;
- Nuclear Hazard;
- Intentional Loss.

Conditions:

- Insurable Interest;
- Duties of Insured;
- Loss Settlement;
- Pair and Set;
- Glass Replacement;
- Appraisal;
- Other Insurance;
- Suit Against Company;
- Company Options;
- Loss Payment;
- Abandonment;
- Mortgage Clause;
- No Benefit to Bailee;
- Nuclear Hazard;
- Recovered Property;
- Volcanic Eruption Period.

ADDITIONAL COVERAGES

All Homeowners forms provide *additional coverage*, coverages provided in addition to the major Section I Coverages A through D. Seven additional coverages are common to all of the Homeowners forms:

- debris removal;
- reasonable repairs;
- trees, shrubs and other plants;
- fire department service charge;
- property removed;
- credit card forgery;
- loss assessment.

An eighth coverage (collapse) is found on all forms *except* the HO-1. For our purposes, we have included coverage for collapse under the "Broad Form perils." As previously noted, technically, collapse is an "additional coverage."

Finally, a ninth additional coverage, building additions and alterations, is provided under the *HO-4 only*. This coverage includes fixtures, improvements or installations made or acquired at the insured's expense and provides 10% of Coverage C as an additional amount of insurance.

Specific dollar limits apply to many of these additional coverages. These dollar limits differ with the edition of the Homeowners Policy used. The important things to remember are that internal limits do exist on certain additional coverages and, usually, these limits can be raised by endorsement.

With this background, let's briefly review the seven common additional coverages.

Debris Removal

Basically, this additional coverage pays for the reasonable expense to remove debris of insured property if a covered peril causes loss.

The cost of debris removal is covered under the property limit in question; however, if the property limit itself is insufficient to pay for loss to damaged property *plus* debris removal, an additional 5% of the property limit will be made available for debris removal.

Debris Removal coverage will cover the expense for the removal of a fallen tree from the residence premises if:

- coverage is not afforded under the additional coverage "Trees, Shrubs and Other Plants (example, a windstorm knocks over an insured's tree);
- the tree is not covered by the insured's policy, but fell as a result of a peril covered by the insured's policy (fire causes an insured's neighbor's tree to fall onto the insured's property).

Reasonable Repairs

The Homeowners Policies will pay for the reasonable repairs made solely to "protect covered property from further damage if an insured peril causes the loss."

This coverage does not increase the limit of liability that applies to the property being repaired.

For example, fire might cause damage to a house that would render it uninhabitable for a few days. Because of this condition, the insurance company might decide that the house should be boarded shut to discourage vandalism or theft.

Trees, Shrubs and Plants

The Homeowners Policies cover trees, shrubs, plants or lawns *on the residence premises* for loss caused by the following insured perils:

- fire or lightning;
- explosion;
- riot or civil commotion;
- aircraft;
- vehicles *not* owned or operated by a resident of the residence premises;
- vandalism and malicious mischief;
- theft.

Trees, shrubs, plants or lawns grown for *business purposes* are *not* covered.

The limit of liability for this coverage is no more than 5% of the dwelling limit nor more than $500 for any one tree, shrub or plant.

Fire Department Service Charge

Homeowners Policies will pay up to $500 for the insured's "liability assumed by contract or agreement for fire department charges" when the fire department is called to fight a covered peril.

If the property is located within the limits of the city, municipality or protection district furnishing the service, no coverage is provided. The fire protection service must be from an "outside" entity.

No deductible applies to this additional insurance.

Property Removed

Property removed from the insured premises to protect it from an insured peril is coverd up to *30 days* at the new location.

This coverage does *not* change the limit of liability that applies to the property removed.

Credit Card Forgery

Under this additional coverage entitled Credit Card, Fund Transfer Card, Forgery and Counterfeit Money, the insurance company agrees to pay up to $500 for:

- the legal obligation of an insured for the illegal use of credit cards registered in the insured's name;
- loss resulting from the unauthorized use of a fund transfer card registered in the insured's name;
- loss to an insured resulting from forgery or alteration of a check;
- loss to an insured through acceptance in good faith of counterfeit United States or Canadian paper currency.

Use of a credit card or fund transfer card by the following will *not* be considered for loss coverage:

- resident of the insured household;
- a person entrusted with either card;

- an insured who has not complied with all terms and conditions under which the cards were issued.

Losses arising out of the *business use* of such cards or the dishonesty of the insured are *not covered.*

All losses resulting from a series of acts committed by any one person is considered to be *one* loss and thereby governed by the $500 maximum limit.

No deductible applies to this additional insurance.

Loss Assessment

The Homeowners Policies will pay up to $1,000 for the insured's share in any loss assessment charged to the insured during the policy period by a corporation/association of property owners for a direct insured loss to property owned collectively.

For example, an insured homeowner might live in a development that provides a communal pool and recreation area. If a peril covered under the insured's Homeowners Dwelling Coverage A (e.g., fire, lightning, etc.) damaged the communal pool, the development association would assess each homeowner. This coverage would cover up to $1,000 of the insured's assessment.

Now that we have reviewed the *additional coverages* provided under Section I, let's review the common exclusions.

SECTION I EXCLUSIONS

The Homeowners forms specifically *exclude* direct or indirect loss caused by any of the following eight reasons:

- Ordinance of Law;
- Earth Movement;
- Water Damage;
- Power Failure;
- Neglect;
- War;
- Nuclear Hazard;
- Intentional Loss.

These first seven exclusions are the same as those described under the Common Dwelling Property exclusions; the eighth, intentional loss, specifically excludes any loss arising out of an act committed:

- by or directed by an insured;
- with the intent to cause loss.

SECTION I CONDITIONS

There are sixteen Section I Conditions found in the newer Homeowners forms and we shall review them briefly as follows:

- Insurable Interest/Limit of Liability;
- Insured's Duties After a Loss;
- Loss Settlement;
- Loss to a Pair or Set;
- Glass Replacement;
- Appraisal;
- Other Insurance;
- Suit Against Us;
- Our Option;
- Loss Payment;
- Abandonment of Property;
- Mortgage Clause;
- No Benefit to Bailee;
- Nuclear Hazard;
- Recovered Property;
- Volcanic Eruption Period.

Insurable Interest/Limit of Liability

No matter how many people have an insurable interest in the covered property, the insurance company will not be liable in any one loss to the insured for more than:

- the amount of the insured's interest in the property at the time of loss;
- the applicable limit of liability.

Insured's Duties After a Loss

In case of a loss to covered property, the insured must:

- notify the company or agent;
- notify the police in the event of a theft loss;
- notify the credit card company or fund transfer in the event of such a loss;
- take reasonable steps to:
  - protect the insured property from further damage;
  - make reasonable and necessary repairs to protect the property;
  - keep accurate records of repairs;
- prepare an inventory of damaged personal property (complete with quantity, description, bills, etc.);
- cooperate with the company by showing the damaged property and pertinent records and documents as well as answering questions, etc.;
- submit a *proof of loss* within *60 days* of the insurer's request. The "proof of loss" is a comprehensive summary of the type of loss, interest of the insured and property involved.

Loss Settlement

This condition provides a very detailed description of how covered losses should be settled. In general, it differentiates between settlements for personal and building property as follows:

- *Personal property losses* are settled on an actual cash value (ACV) basis, not to exceed the cost of repairing or replacing the property involved.
- *Buildings insured under Coverages A and B* are settled on a *replacement cost* basis subject to an 80% coinsurance requirement (described under the Dwelling Property Program).

Loss to a Pair or Set

In case of a loss to a pair or set (if personal property), the insurance company may elect to:

- repair or replace any part to restore the pair or set to its value before the loss;
- pay the difference between the ACV of the property before and after the loss.

Glass Replacement

In the event of damage to glass by a covered peril, it will be replaced with safety glazing materials when required by law.

Appraisal

When the insurer and insured cannot agree on the *amount* of a covered loss, each party will pick an appraiser within *20 days* of receiving a written request from the other. These appraisers, in turn, have *15 days* in which to pick an "umpire."

If they cannot agree on an umpire, this decision will be made by a judge of the court of record in the state where the insured premises is located.

A decision agreed to by any two of three will settle the loss.

The insurer and insured will each pay their own appraiser and split the cost of the umpire.

Other Insurance

If a loss covered under this policy is also covered under another policy, this policy will only pay its proportion of the total coverage involved.

As a result, if there are two $50,000 policies on a $100,000 dwelling and a $10,000 loss results, each policy will consider its share to be $5,000 in keeping with the principal of indemnity.

Suit Against Us (The Insurer)

If the insured wants to sue the insurance company for some reason, the insurance company first demands that:

- all policy provisions have been complied with;
- suit is started within one year of the date of loss.

Our Option

Within *30 days* of receipt of the insured's sworn proof of loss, the insurer may "repair or replace any part of the damaged property with like property" if the insurer gives the insured written notice of this intention.

Loss Payment

Loss is payable to the insured or assigned representative within *60 days* of receipt of the insured's proof of loss.

Abandonment of Property

The insurer is under *no obligation* to accept any property abandoned by the insured.

Mortgage Clause

This mortgage clause is essentially the same as the one found in the Dwelling Property Program.

It is important to remember that:

- any loss payable under Coverages A and B will be paid to the mortgagee (loaner of money) and the insured;
- the mortgagee has *60 days* to file a proof of loss once notified of its need/right to do so;
- the mortgagee will be notified *10 days* before the date of cancellation or nonrenewal.

No Benefit to Bailee

This Homeowners Policy was not designed to benefit a bailee (holder of goods for repair or other services). It was designed for the insured's specific personal exposures.

As a result, the insured cannot assign his coverage to a bailee in the event the insured's property is damaged while in the care, custody or control of the bailee. Bailees need their own coverage to protect their interest in the insured's property while under their (the bailees') control.

Nuclear Hazard

A "nuclear hazard" is defined as any nuclear reaciton, radiation or radioactive contamination.

This clause reiterates that "nuclear hazards" are excluded, but direct loss by fire resulting from a nuclear hazard is covered.

Recovered Property

In the event insured property which has been the subject of a loss settlement is recovered, the *insured* has the option of either keeping it or turning it over to the insurance company.

If the insured chooses the former, the loss settlement will be adjusted down. If the insured chooses the latter, the settlement stands.

Volcanic Eruption Period

One or more volcanic eruption that occurs within a *72 hour period* will be considered as one volcanic eruption.

THE HOMEOWNERS PROGRAM

Section II - Detailed

Preview

Additional Coverages:

- Claims Expenses;
- First Aid Expenses;
- Damage to the Property of Others;
- Loss Assessment.

Common Exclusions:

- Business Pursuits;
- Professional Services;
- Uninsured Location;
- Motor Vehicles;
- Watercraft;
- Aircraft;
- War.

Common Conditions:

- Concealment and Fraud;
- Liberalization Clause;
- Cancellation/Non-Renewal;
- Assignment;
- Subrogation.

SECTION II ADDITIONAL COVERAGE

In additions to Coverage E — Personal Liability and Coverage F — Medical Payments to Others, the Homeowners Program provides the following *additional coverages* under Section II:

- claims expenses;
- first aid expenses;
- damage to property of others;
- loss assessment.

Let's review these additional coverages in detail.

Claims Expenses

As previously noted, liability insurance is designed to cover sums which the insured is "legally obligated to pay." Often, the extent of this legal obligation is one upon which the representative of the insured (the insurance company) and the "third party" involved cannot agree.

The insurance company based on its investigation of the accident in question, might have one opinion as to the cause of injury, extent of damages, etc.; the third party claimant, another. The claimant may seek legal counsel and, eventually, a lawsuit might be started against the insured.

Under the additional coverage of claims expenses, the insurance company agrees to pay:

- the cost of investigating a claim;
- the cost of a *legal defense* initiated by the company;
- *premiums for bonds* required in a suit the company decides to defend;
- *reasonable expenses incurred by the insured* at the company's request, including *actual* loss of earnings, (up to $50/day) for assisting the company in its investigation or defense of a claim or suit;
- *interest on judgment* which accrues after the entry of the judgment;
- *prejudgment interest* awarded against the insured.

First Aid Expenses

This additional coverage provides for expenses incurred by an insured for first aid to others resulting from a bodily injury covered under this policy.

As a result, the company will *not* pay for first aid to any insured.

Damage to Property of Others

Under this coverage, the company will pay the replacement cost of property of others damaged by an insured up to $500 per occurrence.

Under the coverage, the company will *not* pay for property damage:

- recoverable under Section I of the Homeowners Policy;
- caused intentionally by an insured who is 13 years of age or older;
- to property owned by the insured;
- to property owned by a tenant of the insured or a resident in the insured's household;

arising out of:

— business pursuits;

— a premises owned by an insured other than the insured location (listed on the DEC page);

— the ownership, maintenance or use of aircraft, watercraft or other motor vehicles;

Note: this exclusion does *not* pertain to the use of a golf cart at a golf course or other "motorized land conveyances designed for recreation purposes off public roads, not subject to motor vehicle registration and not owned by an insured."

Loss Assessment

As with Section I, Section II provides $1,000 per occurrence for the insured's share or assessment as a member of a group of property owners.

SECTION II - EXCLUSIONS

Common Exclusions

Coverages E and F do *not* apply to bodily injury or property damage arising out of:

- the *business pursuits* of an insured;
- the insured's failure to render *professional services*;
- premises which are *not an insured location*;
- the ownership, maintenance, use, loading or unloading of *motor vehicles*;

  Note: this exclusion does *not* apply to:

  — a trailer not towed by or carried on a motorized land conveyance;

  — a motorized land conveyance designed for recreational use off public roads, not subject to motor vehicle registration and:

  (1) not owned by an insured; or

  (2) owned by an insured and on an insured location.

  — a motorized golf cart when used to play golf on a golf course;

  — a vehicle or conveyance not subject to motor vehicle registration which is:

  (1) used to service an insured's residence;

  (2) designed for assisting the handicapped; or

  (3) in dead storage on an insured location.

- the ownership, maintenance, use, loading or unloading of a *watercraft* (as defined below):

  — Watercraft:

  (1) with inboard or inboard-outdrive motor power owned by an insured;

  (2) with inboard or inboard-outdrive motor power of more than 50 horsepower rented to an insured;

  (3) that is a sailing vessel, with or without auxiliary power, 26 feet or more in length owned by or rented by an insured; or

(4) powered by one or more outboard motors with more than 25 total horsepower if the outboard motor is owned by an insured. But, outboard motors of more than 25 total horsepower are covered for the policy period if:

(a) you acquire them prior to the policy period and:

(i) you declare them at policy inception; or

(ii) your intention to insure is reported to us in writing within 45 days after you acquire the outboard motors.

(b) you acquire them during the policy period.

This exclusion does not apply while the watercraft is stored.

ownership, maintenance, use, loading or unloading of an *aircraft* (as defined below):

— An *aircraft* means any contrivance used or designed for flight, except model or hobby aircraft not used or designed to carry people or cargo.

a war, civil insurrection, rebellion, revolution, etc.

Coverage E - Exclusions

Coverage E - Personal Liability does *not* apply to:

- contractual liability other than that which relates to:
  - — ownership, maintenance or use of the insured location;
  - — where the liability of others is assumed by the insured prior to occurrence.
- B.I. or P.D. of an insured (as defined under the policy);
- P.D. to property rented to, occupied by, used by or in the care, custody and control of an insured; however, fire, smoke or explosion damage to such property is covered.
- B.I. to individuals covered by workers' compensation or disability insurance;
- B.I. or P.D. covered under a nuclear energy liability policy.

Coverage F - Exclusions

Coverage F - Medical Payments to Others does *not* apply to bodily injury:

- to a residence employee not sustained in the course of employment or occurring off-premises;
- to any person eligible to receive workers' compensation and/or disability coverage;
- from any nuclear reaction;
- to any person regularly residing on the insured premises.

GENERAL CONDITIONS

Basically, the same conditions which apply separately to Section I losses concerning limit of liability, duties after a loss, etc. apply to Section II losses. In addition, certain conditions apply jointly to Sections I and II:

- policy period;
- concealment or fraud;

- liberalization clause;
- waiver of policy provisions;
- cancellation/non-renewal;
- assignment;
- subrogation;
- death.

Homeowners Policies apply only to losses/occurrences which occur during the *policy period.*

Coverage will not be provided for insureds who *intentionally* concealed or misrepresented any *material fact* relating to insurance coverage.

A *waiver* or change of a policy provision must be *in writing* in order to be valid.

The following rules pertaining to *cancellation* apply to Homeowners Policies:

- the insured may cancel at any time for any reason;
- the insurance company can cancel for only the following reasons:
  - non-payment of premium;
  - for the *first 60 days* of coverage or less: any reason;
  - after the policy has been in effect for *60 days*: the following reasons:
    - material misrepresentation;
    - change in risk;
  - after one year, the company may cancel for: *any reason* on the anniversary of the policy by informing the insured 30 days in advance. (This is known as non-renewal.)

If the *insured cancels* the policy, unearned premium is returned to the insured on a *short rate basis.*

If the *insurance company cancels* the policy, unearned premium is returned to the insured on a *pro rata basis.*

The *assignment* and *subrogation* clauses of the Homeowners Policies are the ones common to all property policies.

Finally, if an *insured dies* during the policy period, the Homeowners Policy in effect will insure the legal representative of the deceased with respect to the premises and property of the deceased covered under the policy at the time of death.

WORKERS' COMP INSURANCE

Refer to A: WSJ Ji

WORKERS' COMPENSATION INSURANCE

Preview

Workers' Compensation and
Employers Liability Insurance Policy

Part I — *Workers' Compensation Insurance* provides the following benefits to *employees* on a *no-fault* basis:

- unlimited medical benefits (including rehabilitation benefits);
- income benefits;
- funeral benefits.

Part II — *Employers Liability Insurance*:

- B.I. limit per accident;
- B.I. limit by disease — policy limit;
- B.I. limit by disease — per employee.

WORKERS' COMPENSATION INSURANCE

Background

Prior to the enactment of workers' compensation laws throughout the country, the only recourse to employees sustaining injuries on the job was a negligence suit against their employers. This situation did not promote employee morale.

To make matters worse, employers had three common law defenses at their disposal which made it difficult for employees to win cases:

- contributory negligence;
- assumption of risk;
- fellow-servant rule.

"Contributary negligence" held that an employee could not recover damages if he were as much as 1% negligent or, putting it differently, had "contributed" to the negligent situation causing the accident.

"Assumption of risk" maintained that the employee had assumed the risks involved with the job when he accepted the position.

The "fellow-servant rule" was employed when an injury to Employee A was caused by Employee B. As long as the employer exercised good judgment in selecting Employee B, the employer was free of negligence in the aforementioned accident and was not responsible for the injuries to Employee A.

As a result of these common law defenses, few employees recovered for their work-related injuries.

Because employee well-being is so integral to the economic well-being of the country, the states began passing individual workers' compensation laws at the turn of this century. Today, each state has its own workers' compensation laws, social legislation designed to provide guidelines for medical care, cash benefits and rehabilitation services for workers sustaining work-related injuries.

Compulsory or Elective

Workers' compensation laws are either compulsory or elective. The former *requires* that specified benefits be provided by employers covered under the law.

The latter (found only in New Jersey, South Carolina and Texas) allow employers to elect or reject the mandates of the workers' compensation law in these states. However, if employers reject these mandates, they automatically lose the use of the three common law defenses.

Scope of Laws

None of the state workers' compensation laws covers every employer and/or type of employment. Individual state laws must be checked to determine what employers fall within the scope of the law.

In general, the following types of employment are not covered under state workers' compensation laws because of their *temporary* status:

- farm labor;
- domestic employment;
- employees of religious, charitable and non-profit educational institutions;
- casual employees.

Meeting Obligations

Employers can meet their obligations as outlined under the individual workers' compensation laws in one of three ways:

- self-insurance;
- private insurance;
- state funds.

If employers decide to *self-insure*, they must follow the dictates of the states in which they operate as to their financial requirements, reporting procedures, etc.

Workers' Compensation Insurance provided by the voluntary market is the most popular form of compliance with the state laws.

State funds have been created to provide workers' compensation insurance either as an alternative to the voluntary market or as a monopolistic entity, prohibiting the presence of a voluntary market.

An Overview

A "plain English" Workers' Compensation and Employers Liability policy was drafted by the National Council on Compensation Insurance and introduced nationwide in 1984.

This policy insures employers against claims for work-related injuries to employees as well as diseases acquired by them that are compensable by law.

The new Workers' Compensation Policy consists of the following sections:

- Information page;
- General Section;
- Part One — Workers' Compensation Insurance;
- Part Two — Employers Liability Insurance;
- Part Three — Other States Insurance;
- Part Four — Your Duties if Injury Occurs;
- Part Five — Premium;
- Part Six — Conditions.

Let's review the pertinent aspects of each of these sections.

Information Page/General Section

The *Information Page* replaces the Declarations page, but essentially provides the same valuable information:

- name, address and description of insured company;
- policy period;
- a list of the states to which the policy applies;
- liability limits per accident, disease and employee;
- endorsements and schedules.

The *General Section* reinforces the Information Page by generally defining:

- the purpose of the policy;
- who is insured;
- the relationship of the individual workers' compensation laws to the policy.

Under this section, it is noted that the workers' compensation law of any covered state includes amendments to the law that take effect during the policy period. Retroactive law changes are *not* covered.

Part One Workers' Compensation Insurance

Part One — Workers' Compensation Insurance applies to bodily injury (including resultant death) caused by:

- accident; or
- disease.

Bodily injury by accident must occur during the policy period.

Bodily injury by disease must be caused or aggravated by the "conditions of employment." The employee's last day or last exposure to the conditions causing or aggravating the bodily injury by disease must occur during the policy period.

Payments are made to employees regardless of fault as long as the injuries are work-related.

Under this coverage, the insurer agrees to pay the *benefits* required of the insured by law. The term "benefits" includes both compensation for lost wages and medical care including:

- medical benefits;
- income benefits;
- death benefits.

Individual state laws (which provide guidelines for the administration of the workers' compensation benefits) provide *unlimited medical*, hospital, surgical and nursing care for the treatment of work-realted injuries or disease.

Rehabilitation benefits are included within the scope of medical coverage.

Income and *death benefits amounts* are mandated by state law.

Each state requires that a percentage of the workers' regular weekly salary (subject to a weekly minimum and maximum) be provided during a period of partial or total disability. In addition, the loss of income is subject to a maximum dollar amount and/or a maximum time limit.

Although medical treatment is compensated immediately, payment of lost wages is subject to a waiting period which varies by state. If the disability causing the lost wages continues past the waiting period, the lost wages incurred during this waiting period will be covered. Another name for this waiting period is "retroactive period."

In addition to the percentage of wages payable and the period of payment, state workers' compensation laws evaluate the nature of the disability in question when making awards. Injuries are seen as being permanent or temporary in duration; total or partial, in severity. As a result, there are four classifications of disability:

- permanent total disability;
- temporary total disability;
- permanent partial disability; - based on % of whole man disabled x $ value of whole (125,000 - 543)
- temporary partial disability.

Permanent total disability is the most severe: the employee will never work again.

In most states, a worker sustaining a permanent total disability (such as the loss of both hands, feet or eyes) will receive benefits for life.

Temporary total disability renders the employee incapable of working for a given time, but recovery is seen. An example of this classification would be a severely sprained back rendering the employee immobile for 4-6 weeks, but capable of returning to work with no permanency.

Permanent partial disability usually involves an injury which is permanent in nature (loss of an arm, leg, etc.), but will not stop the employee from returning to work.

Temporary partial disability is the least severe classification of disability and usually characterizes an injury that keeps the employee out of work for a few days (example: sprained neck). "Light duty" can be given to such a disability.

Death Benefits include an amount for funeral benefits mandated by law as well as survivors' or dependents benefits.

The surviving spouse of the deceased worker is usually paid for the remainder of his/her life or until he/she remarries. In addition, dependent children receive benefits under state law until they reach the age of 18.

Supplementary Benefits

In addition to paying benefits to employees, the Workers' Compensation coverage will defend the insured employer for legal actions arising out of these payments.

For example, an injured employee might disagree with the type of treatment allowed under workers' compensation insurance or the amount of settlement. In such circumstances, the employee might retain an attorney an seek further reimbursement.

Part One — Workers' Compensation Insurance agrees to investigate such cases, then defend or settle them as needed.

In addition to the *benefits* payable under this section, Part One Workers' Compensation Insurance agrees to pay:

- reasonable expenses incurred at the company's request, but not loss of earnings;
- premiums for bonds to release attachments and for appeal bonds in bond amounts up to the amount payable under this insurance;
- litigation costs taxed against the insured;
- interest on a judgment as required by law until the company offers the amount due under this insurance;
- expenses the company incurs.

Insured's Obligations

The insured employer is responsible for any payment *in excess* of the benefits regularly provided by the workers' compensation law including those required because:

- of the insured's serious and willful misconduct;
- the insured knowingly employs an employee in violation of law;
- the insured fails to comply with a health or safety law or regulation; or
- the insured discharges, coerces or otherwise discriminates against any employee in violation of the workers' compensation law.

Statutory Provisions

The following statements apply to Workers' Compensation Insurance unless they conflict with individual state law:

- an employee's notice of an accident to his/her employer constitutes notice to the insurance company;
- an employer bankruptcy will not relieve the insurer of its responsibilities under the policy;
- benefits are paid directly to the employee, not employer;
- the workers compensation insurance part of this policy automatically conforms to the individual state laws to which it applies.

Part Two Employers Liability Insurance

Under Part One — Workers' Compensation Insurance, the policy provides statutory medical, lost wages and death benefits. Under Part Two — Employers Liability Insurance, the policy pays for damages resulting from B.I. claims initiated by employees.

Under Part One, payments are made *regardless* of fault. Under Part Two, negligence must be established in order for payment to be made.

It is important to remember that this coverage protects the insured employer from negligence suits brought by employees because of work-related injuries. It is very specialized in its scope.

How Coverage Applies

Employers Liability Insurance applies to bodily injury by accident or bodily injury by disease. Bodily injury includes resulting death. Remember:

- The bodily injury must arise out of and in the course of the injured employee's employment;
- The employment must be necessary or incidental to the insured's work in a state or territory listed in the Information Page;
- Bodily injury by accident must occur during the policy period;
- Bodily injury by disease must be caused or aggravated by the conditions of employment. The employee's last day of last exposure to the conditions causing or aggravating such bodily injury by disease must occur during the policy period;
- If the insured is sued, the original suit and any related legal actions for damages for bodily injury by accident or by disease must be brought in the United States of America, its territories or possessions, or Canada.

Part Two — Exclusions

As with any liability coverage, there are exclusions inserted to define coverage. Employers Liability coverage does *not* apply to:

- liability assumed under a contract;
- punitive or exemplary damages because of bodily injury to an employee employed in violation of law;
- bodily injury to an employee while employed in violation of law with the insured's actual knowledge;

- any obligation imposed by a workers' compensation, occupational disease, unemployment compensation, or disability benefits law, or any similar law;
- bodily injury intentionally caused or aggravated by the insured;
- bodily injury occurring outside the United States of America, its territories or possessions, and Canada. This exclusions does not apply to bodily injury to a citizen or resident of the United States of America or Canada who is temporarily outside these countries;
- damages arising out of the discharge of, coercion of, or discrimination against any employee in violation of law.

Employers Liability Insurance is written with separate limits of liability for:

- B.I. per accident;
- B.I. by disease — policy limit;
- B.I. by disease — per employee.

Obviously, the first limit applies to work-related bodily injury sustained by an employee in an accident.

When a disease is involved, there is a policy limit and an employee limit that applies to each occurrence.

Part Three Other States Insurance

Part Three — Other States Insurance covers the insured employer for his responsibilities mandated by the workers' compensation law of a state(s) *other than* those listed on the Information Page. It covers workers' compensation situations arising in states where the insured employer had *not foreseen* activity.

In summary, if the insured employer had foreseen involvement in a given state at the inception of the policy, he should have listed this state on the Information Page.

This protection is important for employers with expanding interstate operations.

Part Four Your Duties If Injury Occurs

If an injury occurs to a covered employee, the employer must notify the insurance company immediately.

In addition, the insured employer must agree to the following duties:

- provide for immediate medical and other services required by the workers' compensation law;
- give the company or its agent the names and addresses of the injured persons and of witnesses, and other information it may need;
- promptly give the company all notices, demands and legal papers related to the injury, claim, proceeding or suit;
- cooperate with the company and assist it as it may request, in the investigation, settlement or defense of any claim, proceeding or suit;
- do nothing after an injury occurs that would interfere with the company's right to recover from others;
- do not voluntarily make payments, assume obligations or incur expenses, except at your own cost.

COMMERCIAL GENERAL LIABILITY

THE COMMERCIAL GENERAL LIABILITY POLICY

Preview

Two versions of the Commercial General Liability Policy:

- occurrence;
- claims-made.

Commercial General Liability coverages:

- Coverage A — B.I. and P.D. Liability;
- Coverage B — Personal and Advertising Injury;
- Coverage C — Medical Payments.

Major supplementary payment: Defense Costs.

THE COMMERCIAL GENERAL LIABILITY POLICY

Background

The Commercial General Liability Policy was issued by the Insurance Services Offices (ISO) in early 1986 to simplify the writing of commercial liability insurance for insurer and insured alike by:

- simplifying the language found in its predecessors;
- combining coverages under one contract that were previously found in many different forms;
- providing new "coverage triggers" for Coverage A—B.I. and P.D. Liability: occurrence or claims made.

All of these changes have been made in response to consumer needs and demands, especially the coverage "triggers."

Traditionally, liability policies were written exclusively on an occurrence basis. The policies provided coverage for occurrences happening during the policy period. This concept seems simple enough, but becomes clouded when considering the definition of an "occurrence": an accident including repeated exposure to conditions.

With cases involving latent bodily injury and long-term exposure illnesses (e.g., involving asbestos), the issue in question is the exact time the injury or damage occurred. When different insurers or different policy limits apply, this issue becomes more complicated.

The "claims-made" version of the Commercial General Liability Policy is designed to respond to *claims made* during the policy period, regardless of when the "accident" causing the claim occurred.

The newer "claims-made" liability policies are expected to end a practice called "stacking," a theory held by the courts that a long series of occurrence policies should be brought into play when considering settlement. For example, if it were determined that a claimant sustained a long disorder due to an "occurrence" over a 10 year period, the courts might require the liability limits for all policies covering the insured for that period be "stacked" on one another to provide a greater settlement resource.

Coverages

The Commercial General Liability Policy provides the following three coverages on an occurrence or claims-made basis:

- Coverage A — Bodily Injury (B.I.) and Property Damage (P.D.) Liability;
- Coverage B — Personal and Advertising Injury Liability;
- Coverage C — Medical Payments.

Let's review these coverages briefly.

B.I. and P.D. Liabiltity;

As previously noted, *bodily injury* means bodily injury, sickness or disease sustained by a person, including death resulting from any of these at any time.

Property damage means physical injury to tangible property, including resulting loss of use to that property as well as loss of use of tangible property that is *not* physically injured.

Under Coverage A of the Commercial General Liability Policy, the company will pay any sums that the insured becomes obligated to pay because of B.I. and P.D. to which the insurance applies. Both the "occurrence" and the "claims made" forms cover the following major liability exposures under Coverage A:

- premises and operations;
- products and completed operations;
- contractual liability for "insured contracts" (specified contracts).

Other liability exposures formerly covered by the Comprehensive General Liability Policy and its Broad Form endorsement (such as fire legal liability, non-owned water craft, etc.) are also covered, but we shall not discuss them in this context. We shall discuss liability exposures which are specifically excluded under this coverage.

Exclusions

Coverage A of the Commercial General Liability Policy does *not* apply to B.I. or P.D. caused by:

- intentional acts on the part of the insured;
- work-related (workers' compensation) activities;
- automobile, aircraft or watercraft accidents;
- dram shop (liquor liability);
- personal property of others in the insured's care, custody and control (3C's);
- discharge of pollutants;

  war.

In addition, damage to property owned by the insured, damage to a product of the insured or the cost to recall a defective product of the insured from the market is specifically excluded from coverage.

Personal and Advertising Injury Liability

Under Coverage B, the Comprehensive General Liability Coverage Form agrees to pay all sums which the insured is legally obligated to pay as damages because of:

- personal injury;
- advertising injury.

Coverage applies to personal injury if it arises out of the conduct of the insured's business; personal injuries are not covered if they result from the insured's personal life.

As you will recall, *personal injury* means injury other than *bodily injury*, arising out of one or more of the following offenses:

- false arrest;
- malicious prosecution;
- wrongful entry or eviction;
- libel;
- slander;
- invasion of privacy.

Coverage applies to *advertising injury* only if caused by an offense committed by the insured in advertising his goods, products or services.

The policy defines "advertising injury" as injury arising out of one or more of the following offenses:

- oral or written publication of material that slanders or libels a person or organization;
- oral or written publication of material that violates a person's right of privacy;
- misappropriation of advertising ideas or style;
- infringement of copyright, title or slogan.

Exclusions

Coverage does not apply to personal injury or advertising injury when the insured:

- knows the oral or written publication is false;
- wilfully violates the law;
- assumes liability in a contract or agreement.

In addition, advertising injuries are not covered if they result from:

- a breach of contract;
- the failure of goods to conform to advertised quality;
- the wrong description of the price of goods, products or services;
- an offense committed by an insured whose business is advertising, broadcasting, publishing or telecasting.

General Comment

A brief review of the insuring agreement and exclusions for Coverage B should lead the reader to certain conclusions:

- Coverage is designed for commercial, not personal exposures;
- Coverage is designed for the average commercial risk, *not* for advertising agencies, publishers, broadcasting or telecasting companies. These companies need specialized coverages to address the extreme nature of their personal injury and advertising injury exposures;
- Finally, this coverage is not designed to pay for an insured's poor workmanship or business practices (the wrong description of the price of goods; breach of contract).

Medical Payments

Under Coverage C, the Comprehensive General Liability Coverage Form agrees to pay medical expenses, incurred within one (1) year of an accident occurring during the policy period, for bodily injury:

- occurring on premises (owned or rented);
- resulting from the insured's operations.

Medical Payments is a "no-fault coverage": Negligence need not be established against the insured in order for the policy to pay.

Medical payments include reimbursement for:

- first aid at the time of the accident;
- necessary medical, surgical, x-ray and dental services, including prosthetic devices;
- necessary ambulance, hospital, professional nursing and funeral services.

Exclusions

Medical Payments will not cover expenses for bodily injury to:

- insureds;
- persons hired to work for the insured;
- tenants of the insured;
- persons entitled to workers' compensation or disability benefits;
- persons involved in an athletic contest;
- persons injured resulting from the products-completed operations hazard;
- persons excluded under Coverage A.

Policy Conditions

Provisions common to all of the Commercial General Liability coverages are contained in the policy conditions section; they include:

- supplementary payments;
- definitions;
- conditions.

Supplementary payments are payments that all general liability coverage parts will pay in addition to the face amount of the policy. They include such liability-related expenses as premiums on bail bonds and reasonable expenses incurred by an insured in assisting the investigation of a claim. The most significant supplementary payments provided by general liability policies are legal expenses incurred by the company in defending an insured for a covered loss.

Defense Costs

Legal expenses incurred by the insurer in defending a suit (whether or not it is false, fraudulent or groundless), are a very important supplementary payments benefit.

Most general liability cases don't reach court. Usually, some agreement is made between the plaintiff attorney and the insurance company. Settlement of a case prior to suit is seen as the preferable course of action to all concerned for a number of reasons, including:

- the illogical basis for many court settlements;
- the costly and lengthy nature of litigation for both sides;
- the changing strength of a case based on time (appear ance and disappearance of witnesses, deaths of key people, etc.).

When a case does go to court, it is a costly matter. Legal and professional fees mount up quickly.

OTHER LIABILITY COVERAGES

Preview

Owners and Contractors Protective Liability Policy covers the contingent liability of:

- owners;
- contractors.

Professional Liability:

- malpractice;
- errors and omissions.

Comprehensive Personal Liability Policy:

- B.I. and P.D. Liability;
- Medical Payments;
- Physical Damage to Property of Others.

Umbrella Liability Excess to Underlying:

- Personal Liability Policies;
- Commercial Liability Policies.

OTHER LIABILITY COVERAGES

Owners and Contractors Protective

The *Owners and Contractors Protective Liability Policy* (hereinafter referred to as the O&CP) has been designed to cover the independent contractor exposure.

The O&CP is written to cover:

- owners, landlords and tenants of property for contingent liability resulting from the negligence of a designated contractor working on the insured's premises;
- contractors for the contingent liability of subcontractors.

The O&CP provides the insured with liability protection in those situations where the law holds the owner or principal contractor liable for the negligence of an independent contractor.

Owners and tenants of buildings usually demand an O&CP policy written in their behalf from contractors prior to the start of any work requiring structural alterations, new construction or demolition. In like manner, general contractors usually require subcontractors to purchase O&CP policies for them, listing the general contractor as the named insured. In this way, the independent contractor exposure is handled separately from any underlying commercial general liability coverage.

Specifically, the O&CP agrees to pay (up to the policy limits) B.I. and P.D. damages for an occurrence arising out of:

- operations performed for the named insured by the contractor designated on the Dec page at the designated location;
- acts or omissions of the named insured in connection with his general supervision of such operations.

Exclusions

The O&CP policy excludes many of the liability exposures covered under the Commercial General Liability Policy as well as "common" liability exposures:

- contractual liability;
- auto/watercraft;
- pollution damage;
- war;
- dram shop;
- workers' compensation;
- 3 C's;
- products;
- completed operations.

In summary, the O&CP is designed to cover one liability exposure and one liability exposure only: The independent contractor or contingent liability exposure. All other liability exposures are excluded from coverage.

Professional

Professional Liability arises from a failure to use due care and the degree of skill required and expected in a particular profession.

A profession is a vocation, calling or occupation involving labor, skill, education and special knowledge of an intellectual nature. This term has been used to describe the labor of theologians, lawyers, doctors, teachers, insurance agents, and any other form of employment requiring a license.

Attorneys may advise clients incorrectly. A doctor may be sued by a patient who has been injured during the course of treatment. A hospital may be sued for invasion of privacy by a former patient because of an unauthorized release of records.

Professional liability insurance is designed to cover such exposures based on "injuries" (bodily injury and personal injury) or "acts of omission."

There are two broad types of professional liability insurance:

- malpractice;
- errors and omissions.

Malpractice insurance addresses the professional liability needs of the medical and allied professions. There are specific malpractice policies for physicians, surgeons, dentists, hospitals, druggists, nurses, opticians, etc.

Errors and omissions insurance addresses the professional liability needs of lawyers, engineers, architects, insurance agents, real estate agents, etc.

As with products liability, the increase in professional liability suits has been alarming in recent years. Many medical specialists pay six-figure insurance premiums for their malpractice insurance. Others are moving into research to avoid the insurance costs altogether.

Some states have organized "medical malpractice pools," whereby members of the medical profession pool their resources to address the professional liability exposure which has been abandoned by many insurance companies.

Because professionals cannot afford "blemishes" against their reputations, malpractice insurance features a loss settlement provision known as "consent to settle a loss." This settlement provision allows the insured physician to decide if a case should be settled or tried in court. The written consent of the insured must be secured before settling a case.

This loss settlement provision is unique to malpractice insurance and not always found in recently issued policies.

Personal

In the broadest sense, there are two major areas of liability exposure: business (commercial) and personal. As we've seen, the former is complex because of the varied nature of business, the many regulations under which it is governed, etc.; the latter is reasonably simple, reflecting the similarity of needs of most individuals in their private lives.

Residence property owners and tenants need protection against liability claims arising out of the ownership, maintenance and use of their premises just as business owners do. And the former have liability exposures for their operations on and off premises (mowing the lawn, repairing a roof, running in a race, etc.) just as the latter do.

The policy providing liability coverage for residence property owners and tenants is the Comprehensive Personal Liability Policy (CPL). It is the same as Section II of the Homeowners (Renters) package policy that most individuals carry on their residence.

The CPL is a comprehensive policy providing liability coverage for practically all non-business activities arising out of:

- the place of residence;
- personal activities (including sports away from home);
- any written agreement (e.g., lease) which does not involve business or professional activities.

In short, the CPL covers the insured's personal premises (including permanent residence, temporary residences, cemetery plots and vacant land) as well as personal operations (including sporting events, social activities and other non-business activities).

CPL coverage has three parts:

- B.I. and P.D. liability;
- Medical payments;
- Physical damage to property of others coverage.

The Personal Liability coverage of the CPL pays all sums (up to the policy limits) which the insured becomes *legally obligated to pay for B.I. and P.D. damages* arising out of personal activities such as:

- the insured's dog bites the insurance salesperson;
- a pedestrian trips on the insured's sidewalk;
- the insured drives a golf ball into the windshield of your Rolls Royce.

Premises Medical Payments cover:

- actual medical expense incurred within three (3) years of the date of the accident;
- necessary medical, surgical, x-ray, dental services, etc.;
- without regard to legal liability.

Coverage extends to guests on the premises as well as people accidentally injured by the activities of the insured or a condition of the insured's premises.

No medical payments coverage is provided for the insured or any tenant or other occupant of the insured's home.

Finally, the *Physical Damage to Property of Others* coverage provides up to $500 for damage to property of others caused by the insured, even though the insured might not be legally at fault.

For example, if the insured borrowed a neighbor's lawn mower and broke it accidentally, the Physical Damage to Property of Others coverage would pay for the loss (up to $500 or whatever the coverage limit is).

Umbrella

Many people, by reason of their economic good fortune, are subject to liability claims of extraordinary proportion, stemming from either business or personal activities. Unfortunately, most liability policies (commercial and personal) have established maximum coverage limits that cannot be exceeded.

In like manner, many people, by reason of their profession or personal activities, require more comprehensive coverage than that provided by their basic (commercial and personal) liability contracts.

Umbrella or *Excess Liability* coverage is designed to provide coverage for:

- higher limits than are generally available under basic liability policies;
- liability exposures either limited or excluded under basic liability policies.

While there is no one umbrella liability policy, it can be described generally as a broad form of liability coverage that is purchased *in addition to underlying general liability and automobile liability policies*. The underlying coverages pay "normal-sized" claims; the umbrella comes into play when basic liability limits are exceeded. As a result, the excess liability policy is seen as superimposing an "umbrella of protection" (hence, the name) over the underlying policies.

A "typical" umbrella policy might require the basic liability contracts to carry a minimum of $100,000 or even $500,000. The umbrella coverage would then come into play after these respective amounts were exceeded.

Although the coverage provided under an umbrella liability policy is far broader than its underlying policies, it is never all risk. Individual umbrella policies must be reviewed for their exclusions.

In recent years, umbrella liability policies have become quite popular with professionals and members of middle and upper management for their business and personal liability exposures.

BOILER/MACH. COVERAGE

know common exclusions

BOILER AND MACHINERY COVERAGE FORM

Various provisions in this policy restrict coverage. Read the entire policy carefully to determine rights, duties and what is and is not covered.

Throughout this policy the words "you" and "your" refer to the Named Insured shown in the Declarations. The words "we," "us" and "our" refer to the Company providing this insurance.

Other words and phrases that appear in quotation marks have special meaning. Refer to Section F - DEFINITIONS.

A. COVERAGE

We will pay for direct damage to Covered Property caused by a Covered Cause of Loss.

1. Covered Property

Covered Property, as used in this Coverage Part, means any property that:

a. You own; or

b. Is in your care, custody or control and for which you are legally liable. In addition to paying for loss to this property, we will defend you against any claim or "suit" alleging liability for damage to this property, subject to the Defense and the Supplementary Payments provisions.

2. Covered Cause of Loss

A Covered Cause of Loss is an "accident" to an "object" shown in the Declarations. An "object" must be in use or connected ready for use at the location specified for it at the time of the "accident."

3. Coverage Extensions

a. Expediting Expenses

With respect to your damaged Covered Property, we will pay the reasonable extra cost to:

(1) Make temporary repairs;

(2) Expedite permanent repairs; and

(3) Expedite permanent replacement.

We restrict the amount payable for Expediting Expenses as explained in the Limits of Insurance section of this Coverage Form.

b. Automatic Coverage for A Newly Acquired Location

We will automatically cover an "accident" to an "object" at a newly acquired location. This automatic coverage begins at the time you acquire the property and continues for 90 days, under the following conditions:

(1) You must inform us, in writing, of the newly acquired location within 90 days of the date you acquire it;

(2) The "object" must be in use or connected ready for use at the time of acquisition and throughout the period of automatic coverage and be of a type that would be included in any "Object" Group Description shown in the Declarations;

(3) The Limit of Insurance and Deductible amount will be the highest amounts shown in the Declarations for the same type of "object;"

(4) We will not be liable under this coverage for Consequential Damage, Business Interruption, or any other indirect loss resulting from an "accident" to an "object;" and

(5) You agree to pay an additional premium as determined by us.

c. Defense

If a claim or "suit" is brought against you alleging that you are liable for damage to property of another in your care, custody or control, that was directly caused by an "accident" to an "object," we will either:

(1) Settle the claim or "suit;" or

(2) Defend you against the claim or "suit," but keep for ourselves the right to settle it at any point.

d. Supplementary Payments

We will pay, with respect to any claim or "suit" we defend:

(1) All expenses we incur;

(2) The cost of bonds to release attachments, but only for bond amounts within the Limit of Insurance. We do not have to furnish these bonds;

(3) All reasonable expenses incurred by you at our request to assist us in the investigation or defense of the claim or "suit," including actual loss of earnings up to $100 a day because of time off from work;

(4) All costs taxed against you in any "suit" we defend;

(5) Pre-judgment interest awarded against you on that part of the judgment we pay. If we make an offer to pay the applicable Limit of Insurance, we will not pay any pre-judgment interest based on that period of time after the offer; and

(6) All interest on the full amount of any judgment that accrues after entry of the judgment and before we have paid, offered to pay, or deposited in court the part of the judgment that is within the Limit of Insurance shown in the Declarations.

These payments will not reduce the Limit of Insurance.

B. EXCLUSIONS

We will not pay for:

1. Ordinance or Law

Any increase in loss caused by or resulting from the enforcement of any ordinance, law, regulation, rule or ruling regulating or restricting repair, replacement, alteration, use, operation, construction or installation. As used here, increase in loss also includes expenses incurred beyond those for which we would have paid if no substance declared to be hazardous to health by a governmental agency had been involved in the "accident."

2. Nuclear Hazard

Loss caused by or resulting from nuclear reaction or radiation, or radioactive contamination, however caused.

3. War and Military Action

Loss caused by or resulting from:

a. War, including undeclared or civil war;

b. Warlike action by a military force, including action in hindering or defending against an actual or expected attack, by any government, sovereign or other authority using military personnel or other agents; or

c. Insurrection, rebellion, revolution, usurped power or action taken by governmental authority in hindering or defending against any of these.

4. Other Exclusions

Loss caused by or resulting from:

a. An explosion. However, we will pay for loss caused by or resulting from an explosion of an "object" of a kind described below and only to "objects" covered by this insurance and as described on an Object Definitions endorsement:

Explosion of any:

(1) Steam boiler;

(2) Electric steam generator;

(3) Steam piping;

(4) Steam turbine;

(5) Steam engine;

(6) Gas turbine; or

(7) Moving or rotating machinery caused by centrifugal force or mechanical breakdown.

b. Fire or explosion that occurs at the same time as an "accident" or that ensues from an "accident." With respect to any electrical equipment forming a part of an "object," this exclusion is changed to read:

Fire or explosion outside the "object" that occurs at the same time as an "accident" or ensues from an "accident."

c. An "accident" that is the direct or indirect result of an explosion or fire;

d. Water or other means used to extinguish a fire, even when the attempt is unsuccessful;

e. Lightning, if coverage for that cause of loss is provided by another policy of insurance you have;

f. Flood. However, if an "accident" results from a flood, we will pay for direct damage to Covered Property caused by the "accident;"

g. An "accident" to any "object" while being tested;

h. An "accident" caused directly or indirectly by earth movement, including but not limited to earthquake, landslide, mudslide, subsidence or volcanic eruption;

i. Lack of power, light, heat, steam or refrigeration;

j. A delay in, or an interruption of, any business, manufacturing or processing activity; or

k. Any other indirect result of an "accident" to an "object."

We will not pay for any loss excluded above even though any other cause or event contributes concurrently or in any sequence to the loss.

C. LIMITS OF INSURANCE

1. We will not pay more than the applicable Limit of Insurance shown in the Declarations for all direct damage to Covered Property that results from any "one accident."

2. The following coverage limitations to our payment for direct damage to Covered Property are part of and not in addition to the Limit of Insurance for this Coverage Form.

   a. Expediting Expenses

   Our payment for Expediting Expenses will be limited to:

   (1) $5,000; or

   (2) What is left of the Limit of Insurance after we pay your loss for Covered Property damaged by an "accident;"

   whichever is less.

   b. Hazardous Substance Limitation

   The following applies despite the operation of the Ordinance or Law Exclusion. This limitation does not apply to damage, contamination or pollution caused by ammonia.

   If Covered Property is damaged, contaminated or polluted as a result of an "accident" to an "object" by a substance declared to be hazardous to health by a governmental agency, the most we will pay for any additional expenses incurred by you for clean up, repair or replacement or disposal of that property is $5,000. As used here, additional expenses mean expenses incurred beyond those for which we would be liable if no substance hazardous to health had been involved.

   c. Ammonia Contamination Limitation

   If Covered Property is contaminated by ammonia as a result of an "accident" to an "object," the most we will pay for this kind of damage, including salvage expense, is $5,000.

   d. Water Damage Limitation

   If Covered Property is damaged by water as a result of an "accident" to covered refrigerating or air conditioning vessels and piping, the most we will pay for this kind of damage, including salvage expense, is $5,000.

Any payment made under Section C will not increase if more than one insured is shown in the Declarations.

D. DEDUCTIBLE

We will not pay for loss or damage resulting from any "one accident" until the amount of loss or damage exceeds the Deductible shown in the Declarations. We will then pay the amount of loss or damage in excess of the Deductible, up to the applicable Limit of Insurance. If more than one "object" is involved in "one accident," only the highest Deductible will apply.

E. BOILER AND MACHINERY CONDITIONS

The following conditions apply in addition to the Common Policy Conditions:

1. **Loss Conditions**

   a. Duties In the Event of Loss or Damage

   You must see that the following are done in the event of loss or damage:

   (1) Give us a prompt notice of the loss or damage. Include a description of the property involved;

   (2) As soon as possible, give us a description of how, when and where the loss or damage occurred;

   (3) Allow us a reasonable time and opportunity to examine the property and premises before repairs are undertaken or physical evidence of the "accident" is removed. But you must take whatever measures are necessary for protection from further damage;

(4) Permit us to inspect the property and records;

(5) If requested, permit us to question you under oath, at such times as may be reasonably required about any matter relating to this insurance or your claim, including your books and records. In such event, your answers must be signed;

(6) Send us a signed, sworn statement of loss containing the information we request to settle the claim. You must do this within 60 days after our request; and

(7) Cooperate with us in the investigation or settlement of the claim.

b. Insurance Under Two or More Coverages

If two or more of this policy's coverages apply to the same loss or damage, we will not pay more than the actual amount of the loss or damage subject to the Limit of Insurance.

c. Legal Action Against Us

No one may bring a legal action against us under this Coverage Part unless:

(1) There has been full compliance with all the terms of this Coverage Part; and

(2) The action is brought within 2 years after the date of the "accident;" or

(3) We agree in writing that you have an obligation to pay for damage to Covered Property of others or until the amount of that obligation has been determined by final judgment or arbitration award. No one has the right under this policy to bring us into an action to determine your liability.

d. Loss Payable Clause

(1) We will pay you and the loss payee shown in the Declarations for loss due to an "accident" to an "object," as interests may appear. The insurance covers the interest of the loss payee unless the loss results from conversion, secretion or embezzlement on your part.

(2) We may cancel the policy as allowed by the Cancellation Condition. Cancellation ends this agreement as to the loss payee's interest.

If we cancel we will mail you and the loss payee the same advance notice.

(3) If we make any payment to the loss payee, we will obtain their rights against any other party.

e. Other Insurance

(1) You may have other insurance subject to the same plan, terms, conditions and provisions as the insurance under this Coverage Part. If you do, we will pay our share of the covered loss or damage. Our share is the proportion that the applicable Limit of Insurance under this Coverage Part bears to the Limits of Insurance of all insurance covering on the same basis.

(2) If there is other insurance covering the same loss or damage, other than that described in (1) above, we will pay only the amount of covered loss or damage in excess of the amount due from that other insurance, whether you can collect on it or not.

In no case will we pay more than the applicable Limit of Insurance.

f. Transfer of Rights of Recovery Against Others To Us

If any person or organization to or for whom we make payment under this Coverage Part has rights to recover damages from another, those rights are transferred to us to the extent of our payment. That person or organization must do everything necessary to secure our rights and must do nothing after loss to impair them.

g. Valuation

(1) We will pay you the amount you spend to repair or replace your property directly damaged by an "accident." Our payment will be the smallest of:

(a) The Limit of Insurance;

(b) The cost at the time of the "accident" to repair the damaged property with property of like kind, capacity, size and quality;

(c) The cost at the time of the "accident" to replace the damaged property on the same site with other property:

(i) Of like kind, capacity, size and quality; and

(ii) Used for the same purpose;

(d) The amount you actually spend that is necessary to repair or replace the damaged property.

(2) As respects any "object," if the cost of repairing or replacing only a part of the "object" is greater than:

(a) The cost of repairing the "object;" or

(b) The cost of replacing the entire "object" on the same site;

we will pay only the smaller of (a) or (b).

The repair parts or replacement "object" must be:

(c) Of like kind, capacity, size and quality; and

(d) Used for the same purpose.

(3) We will not pay you:

(a) If the loss or damage is to property that is obsolete or useless to you; or

(b) For any extra cost if you decide to repair or replace the damaged property with property of a better kind or quality or of larger capacity.

(4) If you do not repair or replace the damaged property within 18 months after the date of the "accident," then we will pay only the smaller of the:

(a) Cost it would have taken to repair; or

(b) Actual cash value;

at the time of the "accident."

Paragraph (4) does not apply to any time period beyond the 18 months that we agree to in writing.

2. General Conditions

a. Additional Insured

If a person or organization is designated in this Coverage Part as an additional insured, we will consider them to be an insured under this Coverage Part to the extent of their interest.

b. Bankruptcy

The bankruptcy or insolvency of you or your estate will not relieve us of an obligation under this Coverage Part.

c. Object Group

All "objects" in use or connected ready for use and included in an "Object" Group Definition will be considered as individually described in the Declarations. The premiums for "objects" included in an "Object" Group Description will be adjusted as follows:

(1) We will base the initial premium for these "objects" on information we obtain. The rates charged will be those in effect on the first day of coverage.

(2) We will charge an additional premium for "objects" that are added to the policy after the effective date of this policy. The additional premium for these "objects" will be computed pro rata.

(3) We will allow a return premium for "objects" that are removed from the policy after the effective date of the policy. The return premium will be computed pro rata from the time the "objects" are disconnected.

d. Policy Period, Coverage Territory

Under this Coverage Part:

(1) The "accident" must occur:

(a) During the Policy Period shown in the Declarations; and

(b) Within the coverage territory.

(2) The coverage territory is:

(a) The United States of America; and

(b) Puerto Rico.

F.

e. Concealment, Misrepresentation or Fraud

This Coverage Part is void in any case of fraud by you relating to it. It is also void if you intentionally conceal or misrepresent a material fact concerning:

1. This Coverage Part;
2. The Covered Property; or
3. Your interest in the Covered Property.

f. Suspension

Whenever an "object" is found to be in, or exposed to, a dangerous condition, any of our representatives may immediately suspend the insurance against loss from an "accident" to that "object." This can be done by delivering or mailing a written notice of suspension to:

(1) Your last known address; or

(2) The address where the "object" is located.

Once suspended in this way, your insurance can be reinstated only by an endorsement for that "object."

If we suspend your insurance, you will get a pro rata refund of premium for that "object." But the suspension will be effective even if we have not yet made or offered a refund.

F. DEFINITIONS

1. **"Accident"** means a sudden and accidental breakdown of the "object" or a part of the "object." At the time the breakdown occurs, it must manifest itself by physical damage to the "object" that necessitates repair or replacement.

   None of the following is an "accident:"

   a. Depletion, deterioration, corrosion or erosion;

   b. Wear and tear;

   c. Leakage at any valve, fitting, shaft seal, gland packing, joint or connection;

   d. Breakdown of any vacuum tube, gas tube or brush;

   e. Breakdown of any electronic computer or electronic data processing equipment;

   f. Breakdown of any structure or foundation supporting the "object" or any of its parts; or

   g. The functioning of any safety or protective device.

   Turbine Units have separate definitions of "accident." If insured, refer to the Turbine Units Object Definitions endorsement.

   If a strike, riot, civil commotion, act of sabotage or vandalism results in an "accident," this insurance applies. However, the War and Military Action Exclusion and the conditions of this Coverage Part still apply.

2. **"Object"** means the equipment shown in the Declarations. Full description of specific "object" categories are found in the Object Definitions endorsement attached to this Coverage Form.

3. **"One Accident"** means:

   If an initial "accident" causes other "accidents" all will be considered "one accident." All "accidents" at any one location that manifest themselves at the same time and are the result of the same cause will be considered "one accident."

4. **"Suit"** means a civil proceeding to which this insurance applies and that may include an arbitration proceeding to which you must submit with our consent.

REVIEW

COMPREHENSIVE REVIEW

LIABILITY BASICS

Review

Four Elements of Negligence:

- Duty;
- Failure to live up to duty;
- Injury;
- Proximate cause.

Common General Liability Exposures:

- Premises;
- Operations;
- Products;
- Completed Operations;
- Contracts;
- Contingent Liability;
- Personal Injury;
- Advertising Injury.

THE COMMERCIAL GENERAL LIABILITY POLICY

Review

Two versions of the Commercial General Liability Policy:

- Occurrence;
- Claims-made.

Commercial General Liability coverages:

- Coverage A — B.I. and P.D. Liability;
- Coverage B — Personal and Advertising Injury;
- Coverage C — Medical Payments.

Major Supplementary Payment: Defense Costs.

OTHER LIABILITY COVERAGES

Review

Owners and Contractors Protective Liability Policy covers the contingent liability of:

- Owners;
- Contractors.

Professional Liability:

- Malpractice;
- Errors and Omissions.

Comprehensive Personal Liability Policy:

- B.I. and P.D. Liability;
- Medical Payments;
- Physical Damage to Property of Others.

Umbrella Liability Excess to Underlying:

- Personal Liability Policies;
- Commercial Liability Policies.

AUTOMOBILE INSURANCE

P.A.P. Liability and Medical Payments

Review

Personal Auto Policy (P.A.P.) — designed to address the various risks associated with the personal use of an auto.

P.A.P. Covered Autos:

- private passenger auto, pickup or van shown in Declarations;
- covered auto acquired during policy period;
- temporary substitutes.

Part A — Liability:

- B.I. and P.D. Liability;
- Supplementary Payments including cost of legal defense;
- *Excludes* loss caused by:
  - — workers' compensation claims;
  - — use of vehicle as a livery;
  - — the automobile business;
  - — intentional acts.

Part B — Medical Payments covers:

- the named insured and family as passengers;
- other passengers of the insured auto.

P.A.P. Uninsured Motorist and Physical Damage

Review

Part C — Uninsured Motorist (U.M.) Coverage — protects the insured and occupants of the insured vehicle against B.I. resulting from an auto accident with:

- Uninsured motorists;
- "Insureds" carrying less than financial responsibility amount;
- Hit and run drivers.

Part D — Coverage for Damage to Your Auto:

- *Collision* — collision and upset;
- *Comprehensive* — other than collision, such as:
  - Fire;
  - Theft;
  - Vandalism;
  - Animals;
  - Glass breakage.

WORKERS' COMPENSATION INSURANCE

Review

Workers' Compensation and Employers Liability Insurance Policy Part I — Workers' Compensation Insurance provides the following benefits to *employees* on a *no-fault* basis:

- Unlimited Medical Benefits (including Rehabilitation Benefits);
- Income Benefits;
- Funeral Benefits.

Part II — Employers Liability Insurance:

- B.I. Limit per accident;
- B.I. Limit by disease — policy limit;
- B.I. Limit by disease — per employee.

MISCELLANEOUS

Nonwaiver Agreements and Reservation of Rights Letters

Nonwaiver agreements and reservation of rights letters serve the following general purposes:

1. To advise the insured that any action taken by the insurance company in investigating the cause of loss, or in ascertaining the amount of loss, is not intended to waive or invalidate any conditions of the policy.
2. To make clear that the intent of the agreement is to permit an investigation of the claim and that neither party, the insured or insurer, will thereby waive any of its respective rights or obligations.

Nonwaiver Agreements. There are two types of nonwaiver agreements: general and specific. Exhibit 5-1 shows an example of a general nonwaiver agreement. A *general nonwaiver agreement* includes as provisions items 1 and 2 in the preceding paragraph. This type of agreement is commonly used in day-to-day claims adjusting whenever there is concern about investigating a claim before the insured has substantially complied with the duties after loss conditions of the policy.

A *specific nonwaiver* is used whenever the company becomes

aware of a specific coverage problem or defense. This situation may arise because of information provided in the initial report, during initial contact with the insured, or during an inspection of the damaged property. Exhibit 5-2 illustrates a specific nonwaiver agreement. It contains the same provisions as a general nonwaiver agreement, but it includes a blank space for the adjuster to enter the specific reason(s) for the coverage question after the words: "Specifically, your policy:". The adjuster should fill in the specific policy provision(s) or exclusion(s) that raise questions regarding coverage. The adjuster should then explain to the insured the reasons for requesting a nonwaiver agreement, request that he or she sign it, and provide a copy of the agreement to the insured. General and specific nonwaiver agreements are usually presented on preprinted forms provided by the insurer.

Reservation of Rights Letters. Reservation of rights letters serve the same purpose as nonwaiver agreements, but they are in letter form. They contain the same general provisions and may include a more specific reason for the coverage question. Again, like the specific nonwaiver, the letter should list the specific coverage part, provision, or exclusion that may apply to the claims situation in question. Some claims supervisors attach photocopies of the specific policy provisions at issue so that there is no confusion on the part of the insured. Reservation of rights letters also include wording by which the insurer reserves the right to raise other coverage issues at a later date when and if they become known.

Reservation of rights letters are usually sent to all named insureds, sometimes with copies to loss payees, by certified mail, return receipt requested, or are hand delivered so the insurance company has evidence of the insured's receipt of the letter. They are used whenever face-to-face contact cannot be made, so that a nonwaiver agreement can be obtained, or whenever the insured has refused to sign a nonwaiver agreement. A reservation of rights letter is as effective as a nonwaiver agreement as long as receipt by the insured can be shown. Some claims managers prefer to use both nonwaiver agreements and reservation of rights letters to ensure that notice to the insured of coverage questions is clearly documented.

PROPERTY & CASUALTY TEST

ALASKA STATE SUPPLEMENT

A. LAWS, RULES AND REGULATIONS: ALL LINES

1. INSURANCE DIRECTOR

Introduction

Because insurance is an enterprise deemed to be "vested in the public interest," it has come under the close scrutiny of government regulation. For some time, state governments have taken the initiative in monitoring insurers by issuing them charters and licensing their agents. After some confusion as to the respective roles of federal and state governments, Congress passed the McCarran-Ferguson Act (Public Law 15) in 1945 which declared that the regulation of the insurance industry should remain with the individual states as long as they perform this task adequately.

The purpose of state insurance regulation is to promote the welfare of the general public and protect its interests. This is accomplished by:

* monitoring insurer solvency;
* reviewing insurer rate plans to ensure reasonable rates;
* maintaining insurance availability.

Since insurance is a promise, it is very important that insurance companies remain solvent to fulfill this promise to compensate the insured in the event of a loss.

A major component of solvency is rate adequacy. If rates are exorbitant, the consumer suffers. If rates are too low, insurers suffer. If insurers suffer to the point of insolvency, everyone suffers.

Finally, because insurance is so important to the general well-being of private individuals and business entities, state insurance departments must ensure its availability by either requiring private insurers to provide it or offering it themselves.

For example, automobile insurance is an area of insurance that is heavily regulated as is malpractice insurance. Insurance companies often do not want to cover every motorist or physician in need of insurance. As a result, the states have to intercede in such matters and act in the public interest.

The insurance industry is regulated through the three state branches of government:

* legislative;
* judicial;
* executive.

Each state's legislature enacts laws which impact every phase of an insurer's operation such as: its formation and licensing; licensing of agents; insurance rates; marketing practices; claims practices, etc.

The judicial branch's influence is profound. New policies are interpreted by the courts. Older policies are reinterpreted in light of the changing world which they address. And the courts render opinions and interpretations on state insurance laws that impact insurer and insured alike.

Finally, each state has an insurance department headed by a director or superintendent, which administers insurance laws and supervises the insurance industry in that state. In addition, as a member of the National Association of Insurance Commissioners (NAIC), a national body over a century old, the state insurance director/superintendent is responsible for keeping abreast of insurance on a national scope.

A. Broad Powers

The Commissioner of Commerce appoints the Director of Insurance. The director serves at the pleasure of the commissioner.

As chief executive officer, the director has the power to:

* administer the department's work;
* appoint and remove officers and other departmental employees;
* perform the duties of the department through various divisions;
* organize the work of the department;
* adopt and issue rules and regulations as established by law, or as necessary for efficient departmental operation (*no regulation may conflict with state law; the director may not enact law; no regulation or amendment is effective until it has been on file as a public record for at least ten (10) days in the director's office*);
* institute legal proceedings for enforcement purposes;
* report to the governor and the legislature on department operations, annually, or as requested or required by law;
* appoint advisory committees;
* maintain departmental headquarters;
* examine record of authorized insurers and licensed agents and brokers;
* hold hearings on insurance matters;
* impose penalties on individuals and companies found guilty of unfair or illegal marketing practices connected with the sale of insurance;
* suspend, revoke or nonrenew an agent's license, giving the licensee not less than fifteen (15) days' notice before the effective date of the license, subject to the right of the licensee to have a hearing; and
* perform any other function as prescribed by law.

If a license is suspended by the Director of Insurance, the licensee may appeal to the superior court.

Orders and notices of the director are not effective unless they are in writing signed by him/her or by his/her authority.

Every order must state its effective date and concisely state:

* its intent or purpose;
* the grounds on which based;
* the provisions of this title under which action is so taken or proposed to be taken (failure to designate a particular provision may not deprive the director of the right to rely on it).

An order or notice may be given by mailing it, postage prepaid, addressed to the producer's principal place of business as last of record in the director's office. A mailed order or notice is considered given when mailed.

Finally, the Director of Insurance has the power to review the insurance records of licensees. *The records of a particular transaction must be kept available and open to the inspection of the director at any business time during the five (5) years immediately after the completion of the transaction.*

B. Adoption of Regulations

The director may promulgate reasonable regulations to effectuate the requirements of the

Insurance Code. No regulation may extend, modify, or conflict with any law of this state or the reasonable implications of the law.

A regulation of the director's office may be made or amended only after a hearing of which *thirty (30) days' notice* was given. If reasonably possible the director must set out the proposed regulation or amendment in or with the notice of hearing.

No regulation or amendment as to which a hearing is required is effective until it has been on file as a public record in the director's office for at *least ten (10) days*.

In addition to any other penalty provided, willful violation of a regulation subjects the violator to the administrative penalty prescribed for that violation.

C. Examination of Records

The director may examine the affairs, transactions, accounts, records, documents and assets of each authorized insurer as often as he/she deems necessary.

Each *domestic* insurer must be examined in detail at least *once every three (3) years*. In addition, the reserve liabilities, including loss adjustment expense reserves, of each domestic insurer must be examined *annually*.

The director must examine insurers applying for an initial Certificate of Authority to transact insurance in Alaska.

The director may examine the affairs, transactions, accounts, records, and assets of each authorized and formerly authorized insurer and each licensed and formerly licensed *managing general agent, reinsurance intermediary broker, reinsurance intermediary manager, surplus lines broker, and surplus lines association* as often as the director considers advisable.

In scheduling and determining the nature, scope, and frequency of examinations, the director may consider any factor or material that the director determines is appropriate, including:

* the results of financial statement analysis and ratios;
* competency of management or change of ownership;
* actuarial opinions;
* reports of independent certified pubic accountants;
* number and nature of consumer complaints;
* results of prior examinations;
* frequency of prior violations of statute and regulation; and
* criteria set out in the Examiner's Handbook most recently approved by the National Association of Insurance Commissioners and in effect when the director conducts an examination.

Examination of an *alien insurer* may be limited to its insurance transactions and affairs in the United States.

Examination of a *reciprocal insurer* may also include examination of its attorney-in-fact to the extent that the transactions of the attorney-in-fact relate to the insurer.

In place of an examination by the director, the director may accept a full report of the last recent examination of a foreign or alien insurer, certified to by the insurance supervisory official of another state, territory, commonwealth, or district of the United States.

The director may use a contract examiner to carry out the functions of this section. The selection of a contract examiner and the award of a contract is subject to state regulation, *except when the director makes a written determination that an emergency selection and contract award is necessary*.

The director must examine a domestic insurer at least once every three (3) years. The director may examine a domestic insurer at any time when the director determines that an examination

or investigation is necessary. Unless the director determines an insurer is in danger of becoming impaired, when the director intends to conduct an *interim examination* of a domestic insurer covering the same subjects that were included in the scope of the last examination report, the director must give *at least ten (10) days' prior written notice* stating the scope and purpose of the examination. In this subsection, "interim examination" means an examination of a domestic insurer that occurs *within three (3) years* after the start of the domestic insurer's examination.

Every person being examined, *or from whom information is sought*, and its officers, employees, agents, and representatives must:

* provide to the director timely, convenient, and free access, at all reasonable hours at its office, the books, accounts, records, documents, files, information, assets, and matters in their possession or control relating to the subject of the examination including all computer or other recordings relating to the property, assets, business, and affairs of the person being examined; and
* facilitate and aid the examination as far as it is in the their power to do so, including providing to the director, *at the expense of the person being examined*, a copy of any document requested during the examination.

The director may suspend, revoke, or refuse to issue or renew a license or authority of a person engaging in the business of insurance or other business under the jurisdiction of the director if the person or an officer, director, employee, or agent of the person refuses to submit to examination or to comply with a reasonable written request of an examiner.

If the director finds *financial or other records* to be inadequate or inadequately kept or posted *or if an insurer's financial records are not kept as required by the Accounting Practices and Procedures Manual currently approved by the National Association of Insurance Commissioners (NAIC)* after the director has *issued an order citing* the inadequacy of the accounts and given a reasonable opportunity to complete or correct the accounting, the director may employ experts to rewrite, post, or balance them *at the expense of the person being examined.*

When conducting an examination under this section, the director may retain attorneys, appraisers, independent actuaries, independent certified public accountants, or other professionals and specialists as examiners, the reasonable cost of which must be paid by the person being examined.

In conducting an examination under this section, the examiner must observe at a minimum those guidelines and procedures set out in the *Examiner's Handbook* currently approved by the National Association of Insurance Commissioners (NAIC) that are consistent with this regulation.

D. Notice and Hearing

The director may conduct hearings on insurance matters as well as:

* conduct investigations;
* administer oaths;
* interrogate licensees and others;
* issue subpoenas to any licensee or any other person in connection with any investigation, hearing or other proceeding.

The director may examine and investigate any person believed to be involved in an unfair method of competition or deceptive practice related to insurance.

When the director suspects an individual or company of engaging in unfair methods of competition or deceptive practices, an investigation is conducted and, if necessary, a hearing is held. The individual or company charged must be given twenty (20) days' written notice of

the hearing time and date, and may be represented at it by legal counsel.

At the hearing, the director may administer oaths, examine and cross-examine witnesses, issue subpoenas, require evidence and receive oral and documented evidence. Hearings are informal: the observance of formal rules of procedure and evidence is not required.

In conducting the hearing the director sits in a quasi-judicial capacity. Within thirty (30) days after termination of the hearing, rehearing, or reargument, the director must make his/her order on hearing, covering matters involved in the hearing, rehearing or reargument, and must give a copy of the order to the same persons given notice of the hearing.

The order must contain a concise statement of the facts found by the director, his/her conclusions, and the matters required by the Insurance Code.

The order may affirm, modify, or nullify a previous action or may constitute the taking of new action within the scope of the notice of hearing.

A person aggrieved by an order of the director may appeal the order to the superior court, using procedures provided by court rule.

After the hearing, the director decides if a violation has occurred. If so, a *cease and desist order* will be issued, requiring that an unlawful action be stopped.

If an individual does not comply with the director's cease and desist order, the commission may institute action in Superior Court to restrain further practices.

The director may modify or repeal any order issued in a case. The case may be reopened if the laws or facts change.

Furthermore, the director may file charges for unfair methods of competition or deceptive acts *not defined in the Code*. If the charges are filed, the hearing will be conducted in the same way as for charges that are defined.

E. Penalties

The Alaska Insurance Code provides penalties for violations of specific Code chapters and activities such as:

* licensing;
* marketing practices;
* cease and desist orders;
* insurer activities.

(1) Licensing

In addition to any other penalty provided by law, a person that the director determines has violated the provisions of the *licensing chapter* is subject to:

* a civil penalty *equal to the compensation promised*, paid, or to be paid, directly or indirectly, to a licensee in regard to *each violation*;
* either a civil penalty of not more than *$10,000 for each violation* or a civil penalty of not more than *$25,000 for each violation if the director determines that the person willfully violated the provisions of this chapter*; and
* denial, nonrenewal, suspension, or revocation of a license.

An order issued by the director that levies a civil penalty *must specify the time period* within which the civil penalty must be fully paid. *The period may not be less than fifteen (15) days or more than one (1) year after the date of the order.*

Upon failure to pay a civil penalty when due, the director must revoke, without further hearing, all licenses of the licensee not already revoked.

(2) Marketing Practices

On the complaint of a person or on the motion of the director, the director may conduct an investigation to determine whether a person is engaged in an *unfair method of competition or unfair method of competition or unfair or deceptive act or practice* prohibited by this chapter.

If the director determines that a person violated a provision of the Insurance Code covering marketing practices, the director must serve upon the person charged an order requiring that person to *cease and desist from engaging in the act or practice.*

In addition to an order issued by regulation, the director may, *after a hearing, order*:

* restitution;
* assess a penalty of not more than $2,500 for *each violation*; or
* $25,000 for engaging in a general business practice in violation of this chapter.

If the director determines after a hearing that the person charged knew or should have known that the person was in violation of this chapter, in addition to the penalty just described, may order:

* a suspension or revocation of the person's license; and
* a penalty of not more than $25,000 for each violation; or
* $250,000 for engaging in the general business practice in violation of this chapter.

(3) Cease and Desist Order

If the director believes that a person has violated a *cease and desist order* issued concerning an illegal marketing activity, the director may certify the relevant facts *to the superior court in the appropriate district.* In addition to the penalties and remedies provided by law, the superior court, upon finding that the *cease and desist order* has been violated, may:

* order the violator to comply with the order;
* pay an additional penalty of not more than $1,000,000 for *each violation*;
* revoke or suspend the violator's license; and
* bar the violator from transacting the business of insurance in the future.

In determining the penalty imposed under this section, the director must consider:

* the amount of loss caused by the violation;
* the amount of benefit derived by the person by reason of the violation; and
* other factors, including the seriousness of the violation, and deterrence of the violator or others.

(4) Insurer Activities

If the director determines, following an appropriate hearing, that an *insurer* has violated the provisions of the Insurance Code pertaining to the following acts, the insurer is subject to specified penalties:

* countersignature requirements;
* writing business through or paying commissions to an unlicensed producer or other individual.

The specified penalty is a civil penalty of not more than *$2,500 for each violation.*

The director may also suspend or revoke the certificate of authority of the insurer. *However, the violation in question does not invalidate the insurance contract.*

Upon suspending or revoking an *insurer's certificate of authority*, the director must immediately give notice to the insurer and to its agents of record in this state in the director's

office.

The suspension or revocation will automatically suspend or revoke, as the case may be, the authority of all its agents to act as agents of the insurer in this state. The director must state this fact in the notice to agents.

The director must also publish notice of the revocation in one (1) or more newspapers of general circulation in this state.

2. DEFINITIONS

A. Authorized and Unauthorized

An insurance company licensed to do business in Alaska is said to be *authorized* in this state.

Conversely, an insurance company *not allowed* to do business in Alaska is said to be *unauthorized*.

B. Domestic, Foreign and Alien

A *domestic insurer* in Alaska is an insurance company formed under the laws of Alaska.

A *foreign insurer* is an insurance company formed under the laws of a United States jurisdiction other than Alaska.

An *alien insurer* is an insurance company formed under the laws of a country other than the United States, its districts, territories, commonwealth, possessions, and the Panama Canal Zone.

C. Stock and Mutual

In addition to being classified by their location (domestic, foreign and alien), insurance companies also are classified by their form of ownership and mode of operation (stock and mutual).

A *stock* insurance company is an incorporated company with its capital divided into shares. Stock insurers are owned by their stockholders.

A *mutual insurer* is an incorporated company without permanent stock and owned by its policyholders.

D. Transacting Insurance

"Transacting insurance" includes:

* soliciting insurance business;
* negotiating or binding policies of insurance;
* communicating with insureds concerning insurance policies;
* transmitting funds between insureds and insurers.

E. Certificate of Authority

A *certificate of authority* is a legal document issued by the Department of Insurance to insurance companies giving them authority to engage in the business of insurance in Alaska.

As a result, authorized or admitted insurers receive certificates of authority to operate in Alaska.

Certificates of authority are to insurance companies what licenses are to agents: a tangible representation of state insurance department given authority.

F. Premium

"Premium" means the consideration for insurance, by whatever name called, and by whatever method paid or collected, including an assessment, or membership, policy, survey, inspection, service or similar fee or charge made in consideration for an insurance contract.

In short, the premium is the amount of money that an insurer charges an insured for coverage.

The premium is determined by multiplying a rate for a given line of insurance by the amount of insurance (usually written in multiples of $1,000) desired.

3. LICENSING

A. Purposes

The purposes of licensing are to:

* encourage improvement in the professional competence of insurance licensees;
* provide maximum freedom of marketing methods for insurance, consistent with the interests of the public in this state;
* preserve and encourage competition at the consumer level;
* limit the adverse effects of imperfect competition on the cost of insurance;
* regulate insurance marketing practices.

B. Persons Required to be Licensed

Resident individuals, partnerships and corporations wanting to solicit and negotiate contracts of insurance in Alaska must be licensed by the insurance department as one of the following:

* insurance producer; + solicitor
* managing general agent; + actuary
* third party administrator;
* reinsurance intermediary broker;
* reinsurance intermediary manager;
* surplus lines broker;
* independent adjuster.

For the protection of the people of this state, the director may not issue or renew a license except in compliance with this regulation. Furthermore, the director may not issue a license to a person found by the director to be untrustworthy, incompetent, or who has not established to the satisfaction of the director that the person is qualified under this chapter.

To qualify for issuance or renewal of an individual or individual in the firm license, an applicant or licensee must comply with this regulation and:

* be 19 years of age or older with a high school or General Education Development diploma or equivalent;
* be a bona fide resident before issuance of the license and actually reside in the state, if for a resident license;
* successfully pass a required examination;
* be a trustworthy person;
* not use or intend to use the license for the purpose principally of writing "controlled business."

"Controlled business is insurance written by a licensee on his/her own family or business associates.

A licensee may not earn or receive an aggregate amount in commission, service fees, brokerage, or other valuable consideration, directly or indirectly represented by the controlled business *that exceeds 50 percent (50%) of the aggregate amount in compensation, commission, service fees, brokerage, or other valuable consideration represented by all other insurance business in a calendar year.*

(1) Insurance Producer

An *insurance producer* is a person (individual, partnership or corporation) who:

* solicits, negotiates, effects, procures or delivers a policy of insurance; or
* renews, continues or binds a policy of insurance to the extent authorized by the insurer.

The term "insurance producer" includes agents and brokers.

An *agent* is a person (individual, partnership or corporation) *appointed* by an insurer to:

* solicit applications for insurance or annuities on its behalf;
* effectuate and countersign (if authorized to do so) insurance contracts, except:
  - life insurance;
  - disability insurance contracts; and
  - annuities; and
* collect premiums.

A *broker* is a person (individual, partnership or corporation) who is *not an agent of the insurer* and who, on behalf of the insured, for compensation as an independent contractor:

* solicits, negotiates or procures insurance or reinsurance; or
* *aids* in the solicitation, negotiation, procurement, renewal or continuance of insurance or reinsurance.

In an insurance transaction, an agent represents the insurer; a broker, the insured.

(a) Producer Qualifications

In addition to the general qualifications for licensure, an applicant for issuance or renewal of an insurance producer license must:

* possess the competence necessary to fulfill the responsibilities of an insurance producer;
* not have had a license suspended or revoked within the previous four (4) calendar years, if previously licensed in good standing in this state as an insurance producer;
* *for a fraternal society limited insurance producer license*: file with the application a statement by an officer or director of the appointing fraternal society that affirms that the society has satisfied itself that the applicant is trustworthy and competent to act as its insurance agent;
* either be currently registered with the federal Securities and Exchange Commission as a broker-dealer or personally take and pass, to the satisfaction of the director, tests of the knowledge and competence of the applicant concerning securities, for a license with a scope that includes variable contracts; and
* maintain *a bond in the amount of $10,000*, unless a greater amount is required by another provision of this title. This requirement *does not apply* to any licensee who acts solely on behalf of admitted insurers as an agent and does not receive money required to be received in the fiduciary account of the license.

(b) Trainee Insurance Producers

Except for life, disability, and annuity insurance, a person who has not passed the required examinations, but who otherwise meets the requirements for licensure, may be employed by a licensed insurance producer as *a trainee insurance producer.*

Before a trainee may transact insurance, the licensed insurance producer employing the trainee must apply to the director and receive the trainee insurance producer license.

The director will terminate a trainee insurance producer license unless the individual has:

* not later than four (4) months after the effective date of the trainee insurance producer license, complied with the insurance producer licensing requirements *concerning the insurance laws and regulations of this state*; and
* within eight (8) months after the effective date of the trainee insurance producer license, complied with the insurance producer licensing requirements *concerning the knowledge and competence* as well as the duties and responsibilities as a licensee.

Upon satisfying these requirements, a trainee insurance producer may apply *within thirty (30) days* for an insurance producer license.

A licensed trainee insurance producer:

* must at all times be working at the direction and under the supervision of the employing licensed insurance producer (File and record documentation must reflect the direction and supervision; activities must be in the name of the employing licensed insurance producer, who is responsible for all actions of the trainee insurance producer.);
* is restricted to *assisting* the employing licensed insurance producer to:
  - prepare applications; binders; certificates of insurance; schedules of equipment, vehicles, drivers; loss notices to insurers; invoices; and
  - perform clerical functions for which a license is not required.

  The file and record documentation must reflect compliance with these restrictions.
* may not transact business away from the place of business with clients or insurers unless a licensed insurance producer physically accompanies the trainee.

In addition to any other penalty provided by law, the director may revoke the trainee license of a trainee insurance producer that the director determines has violated the provisions of this section. A licensee or other person having possession or custody of the license must immediately surrender the license to the director either personally or by certified mail.

In addition to any other penalty provided by law, if the director determines that the employing licensed insurance producer knew or should have known that a trainee insurance producer violated this section, the employing licensed insurance producer and firm, principal and manager, if any, are subject to either of the following penalties:

* a civil penalty of not more than *$10,000 for each violation*; or
* a civil penalty of not more than *$25,000 for each violation* if the director determines that the person willfully violated the provisions of the Insurance Code; and
* denial, nonrenewal, suspension or revocation of a license.

(c) Appointment of an Insurance Producer as an Agent

A person may not act as a representative of a particular admitted insurer, or accept applications on behalf of an admitted insurer, *unless the person is licensed as an insurance producer* and is or becomes an *appointed agent* of the admitted insurer.

An admitted insurer or managing general agent of an admitted insurer may not enter into an agency agreement with an insurance producer unless the managing general agent and the

insurance producer are licensed and there is in effect a written agency agreement that specifically sets out the duties, functions, powers, authority, and compensation of all parties to the contract. The written agreement must be kept in the permanent records of the insurer or managing general agent, if any, and the insurance producer, and be open to inspection by the director.

All money collected for the account of an insurer must be held by the insurance producer *in a fiduciary account* (one of trust). The insurance producer must comply with all applicable fiduciary account statutes and regulations.

An agency agreement may not be assigned in whole or in part by the insurance producer.

If the agency agreement permits the insurance producer to settle a claim on behalf of the insurer, the following activities are required:

* a claim must be reported to the insurer within thirty (30) days;
* a copy of the claim file must be sent to the insurer;
* all insurance claim files must be the property of the insurer or managing general agent, if any, and insurance producer.

Note: Upon an order of liquidation of the insurer, the files become the sole property of the insurer or the insurer's estate. The insurance producer must have reasonable access to and the right to copy the files on a timely basis.

An insurance producer is subject to the unfair trade practices and fraud provisions of the Insurance Code.

An *insurance producer may not*:

* bind reinsurance or retrocessions on behalf of the insurer;
* commit the insurer to participate in insurance or reinsurance syndicates;
* appoint an agent or subagent;
* jointly employ an individual who is employed by the insurer or by the managing general agent; or
* delegate insurance producer authority to another person.

An agency appointment may not extend, directly or indirectly, to a client for whom:

* the insurance producer is a producing broker; or
* insurance is exported to nonadmitted insurers.

A reinsurance intermediary manager (to be discussed) may not enter into an agency agreement with an insurance producer unless both parties are licensed and there is in effect a written agency agreement that specifically sets out the duties, functions, powers, authority, and compensation of all parties to the agreement. The written agreement must be kept in the permanent records of the reinsurance intermediary manager, the reinsurer, and the insurance producer, and be open to inspection by the director.

A written agreement must contain the following *minimum provisions*:

* money collected for the account of a reinsurer must be held by the insurance producer in fiduciary account and the insurance producer must comply with all applicable fiduciary account statutes and regulations;
* the agreement may not be assigned in whole or in part by the insurance producer;
* the agreement may not permit the insurance producer to settle claims on behalf of the reinsurer or reinsurance intermediary manager; and
* the insurance producer may not:

- jointly employ an individual who is employed with the reinsurer or reinsurance intermediary manager; or

delegate insurance producer authority to another person.

(d) Appointment of Insurance Producers as Brokers

A client who appoints an insurance producer as its broker in this state or relative to a subject resident, located, or to be performed in this state must execute a written contract that specifically sets out the duties, functions, powers, authority, and compensation of the insurance producer, if the broker is compensated by a fee paid the client or by a combination of a fee paid by a client and a commission paid by an insurer with which coverage has been placed. *The written contract must be kept in the permanent records of the insurance producer and be open to inspection by the director.*

The insurance producer may not knowingly accept payment of a premium for coverage until the coverage has been authorized by the insurer. This regulation does not apply to renewal of existing coverage placed by the insurance producer, or to a premium deposit for the purchase of insurance. *A premium deposit must be returned to the client if coverage is not obtained within ten (10) working days.*

An insurance producer appointed as a client's broker may only receive *compensation* if the compensation is a:

* fee that requires the insurance producer to offset or reimburse the client for the full amount of a commission earned by the insurance producer;
* combination of a fee paid by a client and a commission paid by an insurer with which coverage is placed that may offset or reimburse a client for all or part of a commission earned by the insurance producer if the amount of the commission is disclosed to the client; or
* commission paid by an insurer with which coverage has been placed.

A contract between a client and an insurance producer may not be assigned in whole or in part by the insurance producer.

An insurance producer appointed as a broker by a client may act as an appointed agent of an admitted insurer and may accept an application, bind coverage, and collect a premium from the client on behalf of the admitted insurer.

A controlling insurance producer may not be appointed as a broker by a client in this state or relative to a subject resident, located, or to be performed in this state unless:

* the controlling insurance producer has disclosed in writing to the client the relationship between the controlling insurance producer and the controlled insurer;
* each client has acknowledged receipt of the disclosure; and
* a copy of the acknowledged disclosure is maintained by the controlling insurance producer in its records.

The records must be available for inspection by the director.

Money paid by a client to an insurance producer for insurance premiums must be held by the insurance producer in a fiduciary account. The insurance producer must comply with applicable fiduciary account statutes and regulations.

An insured is entitled to coverage or a return premium and the premium is considered received by the insurer if:

* the premium payment made to the insurance producer was, at the time made, designated for specific coverage; and
* the insurer accepted or acknowledged coverage by issuing a policy binder or other evidence of temporary insurance; or
* the insurance producer received information from the insurer in the normal course of business that the insurance had been granted.

(e) Operating Requirements for Controlling Insurance Producers

A "controlling insurance producer" is an insurance producer that, directly or indirectly, controls an insurer.

A "controlled insurer," in turn, is an admitted insurer that is controlled, directly or indirectly, by an insurance producer.

If the aggregate amount of gross written premium on a business placed by a controlling insurance producer *exceeds five percent (5%) of the admitted assets of the controlled insurer for a calendar year* as reported in the insurer's most recent financial statement, the controlling insurance producer may not place business with the controlled insurer and the controlled insurer may not accept business from the controlling insurance producer *unless a written contract is in effect between the parties that*:

* establishes the responsibilities of each party, indicates each party's share of responsibility for each particular function, and specifies the division of responsibilities;
* has been approved by the board of directors of the controlled insurer.

In addition, the written agreement must contain the following *minimum provisions*:

* the controlled insurer may terminate the contract for cause upon written notice sent by certified mail to the controlling producer and may suspend the authority of the controlling insurance producer to write business during a dispute regarding the cause for termination;
* the controlling insurance producer must render accounts to the controlled insurer detailing all transactions including information necessary to support compensation, commissions, charges, and other fees received by, or owing to, the controlling producer;
* the controlling insurance producer must remit money due under the contract to the controlled insurer *at least monthly*;
* premiums or installments collected must be due *not later than ninety (90) days after the effective date of coverage* placed with the controlled insurer;
* money collected for the account of a controlled insurer must be held by the controlling insurance producer in a *fiduciary account*, except a controlling insurance producer not
- required to be licensed must maintain its fiduciary account in compliance with the requirements of its domiciliary jurisdiction;
* a licensed controlling insurance producer must comply with all applicable fiduciary account statutes and regulations;
* a fiduciary account must be used for all payments on behalf of the controlled insurer;
* the controlling insurance producer must maintain separate records for each controlled insurer in a form usable by the controlled insurer; the controlled insurer or its authorized representative must have the right to audit and the right to copy all accounts and records related to the controlled insurer's business; the director, in addition to authority granted in this title, must have access to all books, bank accounts, and records of the controlling insurance producer in a form usable to the director;
* the contract *may not be assigned* in whole or in part by the controlling insurance producer;
* the controlled insurer must provide, and the controlling producer must follow, written underwriting standards, rules, procedures, and manuals that must include the conditions for acceptance or rejection of risks, including:
- types of risks that may be written;
- maximum limits of liability;
- applicable exclusions;

- territorial limitations;
- policy cancellation provisions;
- the maximum policy term;
- the rating system; and
- basis of the rates to be charged;

* the underwriting standards, rules, procedures, and manuals must be the same as those applicable to comparable business placed with the controlled insurer by licensees other than the controlling licensee;
* the rates and terms of the controlling insurance producer's compensation including commissions, charges, and other fees may not be greater than those applicable to comparable business placed with the controlled insurer by licensees other than the controlling licensee;
* the controlled insurer must establish a limit, that may be different for each kind or class of business, on the amount of premium that the controlling insurance producer may place with the controlled insurer in relation to the controlled insurer's surplus and total writings;
* the controlled insurer must notify the controlling insurance producer if an applicable limit is approached and the controlling insurance producer may *not* place and the controlled insurer may not accept business *if the aforementioned limit has been reached*;
* if the contract provides that the controlling insurance producer, on insurance placed with the controlled insurer, is to be compensated contingent upon the controlling insurer's profits on the placed insurance, the contingent compensation may not be determined or paid until:

- at least five (5) years after the premiums are earned on casualty business and at least one (1) year after the premiums are earned on any other insurance;
- a later period established by the director for specified kinds or classes of insurance; and
- not until the profits have been verified;

* the controlling insurance producer may negotiate but not bind reinsurance on behalf of the controlled insurer on insurance that the controlling insurance producer places with the controlled insurer. The controlling insurance producer may bind facultative reinsurance contracts under obligatory agreements if the contract with the controlled insurer contains reinsurance underwriting guidelines including, for both reinsurance assumed and ceded, a list of reinsurers with which automatic agreements are in effect, the coverage and amounts or percentages that may be reinsured, and commission schedules.

A controlling insurance producer may be examined by the director as if it were the controlled insurer.

If the conservator, rehabilitator, or liquidator of a controlled insurer or formerly controlled insurer has reason to believe that the controlled insurer or formerly controlled insurer suffered loss or damage arising out of a failure to comply with this section by the controlling producer or another person, the conservator, rehabilitator, or liquidator may maintain a civil action for recovery of damages or other relief for the benefit of the controlled insurer or its estate.

If the director determines after a hearing that a controlling insurance producer caused losses out of a violation of this section to a controlled insurer, the director may order the controlling insurance producer to make restitution to the controlled insurer, the rehabilitator, or the liquidator of the controlled insurer for the loss.

This regulation does not apply to:

a person appointed to act on behalf of the controlled insurer as a managing general agent;

* a person who receives no compensation based upon the amount of premiums written with the controlled insurer and who places insurance only with:

  the controlled insurer;

  the controlled insurer and an admitted member or admitted members of the insurer's holding company system; or - the controlled insurer's parent, affiliate, or subsidiary if admitted in this state;

  a person who does not accept insurance placements directly from an insured and who only accepts insurance placements from a nonaffiliated subagent;

* a controlled insurer and its controlling insurance producer if, except for insurance written through a residual market facility under this title, insurance placements are accepted only from a controlling producer, an insurance producer controlled by the controlled insurer, or a producer that is a subsidiary of the controlled insurer;

  a risk retention group; or

  a risk appointment plan or assigned risk pool.

(f) Penalties

In addition to any other penalty provided by law, a person that the director determines has violated the provisions of the Insurance Code pertinent to insurance producers is subject to:

* a civil penalty equal to the compensation promised, paid, or to paid, directly or indirectly, to a licensee in regard to *each violation*;
* either a civil penalty of not more than *$10,000 for each violation* or a civil penalty of not more than *$25,000 for each violation if the director determines that the person willfully violated the provisions of this chapter*; and
* denial, nonrenewal, suspension, or revocation of a license.

An order issued by the director that levies a civil penalty *must specify the time period* within which the civil penalty must be fully paid. *The period may not be less than fifteen (15) days or more than one (1) year after the date of the order.*

Upon failure to pay a civil penalty when due, the director must revoke, without further hearing, all licenses of the licensee not already revoked.

(2) Managing General Agent

A *managing general agent* is a person (individual, partnership or corporation) that:

* has authority to exercise general supervision over the business of one or more admitted insurers; and
* performs administrative functions normally performed by the insurer, including:

- claims administration and payment;
- marketing administration;
- agent appointment;
- premium accounting;
- premium billing;
- coverage verification;
- final underwriting authority; and
- certificate issuance.

(a) Qualifications

In addition to the general qualifications previously described, to qualify for issuance or renewal of a managing general agent license, an applicant or licensee *must have at least three (3) years active working experience within the previous ten (10) calendar years in insurance administrative functions* which, in the director's opinion, exhibits the applicant's ability to competently perform the administrative functions for all kinds and classes of insurance applied for.

The director may require that a managing general agent maintain:

* a bond in an amount acceptable to the director and conditioned in that the managing general agent will conduct business as required by this title; and
* an errors and omissions insurance policy acceptable to the director.

(b) Trainee Managing General Agents

An individual licensed in this state as an insurance producer who does not have the experience required to be licensed as a managing general agent, but who otherwise meets the requirements may be employed by a licensed managing general agent as a trainee managing general agent, subject to the provisions of this section.

Before an individual may transact insurance as a managing general agent, a managing general agent employing the trainee managing general agent must submit to the director the application of the trainee managing general agent with a required fee.

Upon satisfying the managing general agent experience requirement, a trainee managing general agent may apply within thirty (30) days for a managing general agent license.

A trainee managing general agent must at all times be working at the direction and under the supervision of the employing licensed managing general agent. File and record documentation must reflect the direction and supervision. The activities of a managing general agent trainee must be in the name of the employing managing general agent. *A managing general agent who employs a trainee is responsible for all actions of the trainee managing general agent.*

A trainee managing general agent is restricted to:

* assisting the employing licensed managing general agent in preparing applications; binders; certificates of insurance; schedules of equipment, vehicles, drivers; loss notices to insurers; and invoices; and
* performing clerical functions for which a license is not required.

The file and record documentation must reflect compliance with this subsection.

A trainee managing general agent may not transact business away from the place of business with clients or insurer unless a licensed managing general agent physically accompanies the trainee.

In addition to any other penalty provided by law, the director may revoke the trainee license of a trainee managing general agent who the director determines has violated the provisions of this section. A licensee or other person having possession or custody of the license must immediately surrender the license to the director either personally or by certified mail.

If the director determines that the employing managing general agent *knew of or should have known* that a trainee managing general agent violated this section, the employing managing general agent and firm, principal, and manager, if any, are subject to the following penalties:

* a civil penalty equal to the compensation promised, paid, or to be paid, directly or indirectly, to a licensee in regard to *each violation*;
* either a civil penalty of not more than *$10,000 for each violation* or a civil penalty of not more than *$25,000 for each violation if the director determines that the person willfully violated the provisions of this chapter*; and

* denial, nonrenewal, suspension, or revocation of a license.

An order issued by the director that levies a civil penalty *must specify the time period* within which the civil penalty must be fully paid. *The period may not be less than fifteen (15) days or more than one (1) year after the date of the order.*

Upon failure to pay a civil penalty when due, the director must revoke, without further hearing, all licenses of the licensee not already revoked.

(c) Authority of Managing General Agents

A managing general agent has only the authority consistent with this title that is conferred by an admitted insurer.

A managing general agent, resident or nonresident, qualified and licensed under this chapter, may exercise the powers conferred by this title upon insurance producers and independent adjusters only for the kinds or classes of insurance and within the scope authorized by the insurer appointing the managing general agent.

(d) Operating Requirements for Managing General Agents

An insurer may not transact business with a managing general agent unless:

* the insurer holds a certificate of authority in this state;
* the managing general agent is licensed or when the managing general agent is operating only for a foreign insurer, is licensed by its resident insurance regulator in a state that the director has determined has enacted provisions substantially similar to those contained in this regulation and the state is accredited by the National Association of Insurance Commissioners (NAIC);
* a written contract is in effect between the parties that establishes the responsibilities of each party, indicates both party's share of responsibility for a particular function and specifies the division of responsibilities.

This written contract between an insurer and a managing general agent must contain the following provisions:

* the insurer may terminate the contract for cause upon written notice sent by certified mail to the managing general agent during a dispute regarding the cause for termination;
* the managing general agent must render accounts to the insurer detailing all transactions and remit money due under the contract to the insurer *at least monthly*;
* all money collected for the account of an insurer must be held by the managing general agent in a fiduciary account;
* the managing general agent must comply with all applicable fiduciary account statutes and regulations;
* a fiduciary account must be used for all payments on behalf of the insurer;
* the managing general agent may not retain *more than three (3) months* estimated claims payments and allocated loss adjustment expenses;
* the managing general agent must maintain separate records for each insurer in a form usable by the insurer; the insurer or its authorized representative must have the right to audit and the right to copy all accounts and records related to the insurer's business; the director, in addition to authority granted in this title, must have access to all books, bank accounts, and records of the managing general agent in a form usable to the director;
* the contract may not be assigned in whole or in part by the managing general agent.

If the contract permits the managing general agent to do *underwriting*, the contract must

include the following:

* the managing general agent's maximum annual premium volume;
* the rating system and basis of the rates to be charged;
* the types of risks that may be written;
* maximum limits of liability;
* applicable exclusions;
* territorial limitations;
* policy cancellation provisions;
* the maximum policy term; and
* that the insurer must have the right to cancel or not renew a policy of insurance subject to applicable state law.

If the contract permits the managing general agent to *settle claims* on behalf of the insurer, the contract must include the following:

* written settlement authority must be provided by the insurer and may be terminated for cause upon the insurer's written notice sent by certified mail to the managing general agent or upon termination of the contract, but the insurer may suspend the settlement authority during a dispute regarding the cause of termination;
* claims must be *reported* to the insurer *within thirty (30) days*;
* a copy of the claim file must be sent to the insurer upon request or as soon as it becomes known that the claim:

- has the potential to exceed an amount determined by the director or exceeds the limit set by the insurer, whichever is less;
- involves a coverage dispute;
- may exceed the managing general agent's claims settlement authority;
- is open for more than six (6) months;
- involves extra contractual allegations; or
- is closed by payment in excess of an amount set by the director or an amount set by the insurer, whichever is less;

* each party must comply with unfair claims settlement statutes and regulations;
* transmission of electronic data at least monthly if electronic claim files are in existence; and
* claim files must be the property of both the insurer and managing general agent; upon an order of liquidation of the insurer, the files must become the sole property of the insurer or the insurer's estate; the managing general agent must have reasonable access and the right to copy the files on a timely basis;
* if the contract provides for sharing of interim profits by the managing general agent, and the managing general agent has the authority to determine the amount of the interim profits by establishing loss reserves, by controlling claim payments, or in any other manner, interim profits may not be paid to the managing general agent until:

- one (1) year after they are earned for property insurance business and five (5) years after they are earned on casualty business;
- a later period established by the director for specified kinds or classes of insurance; and
- the profits have been verified;

* if the insurer is domiciled in this state or the managing general agent has a place of business in this state, a copy of the contract must be filed with and approved by the

director at least thirty (30) days before the managing general agent transacts business on behalf of the insurer; and

* if the contract is not required to be approved in advance by the director, the insurer must provide written notification to the director within thirty (30) days of the entry into or termination of a contract with a managing general agent; the notice must include a statement of duties to be performed by the managing general agent on behalf of the insurer, the kinds and classes of insurance for which the managing general agent has authorization to act, and other information required by the director.

The managing general agent may not:

* bind reinsurance or retrocessions on behalf of the insurer, except that the managing general agent may bind facultative reinsurance contracts under obligatory agreements if the contract with the insurer contains reinsurance underwriting guidelines including, for both reinsurance assumed and ceded, a list of reinsurers with which automatic agreements are in effect, the coverage and amounts or percentages that may be reinsured, and commission schedules;
* commit the insurer to participate in insurance or reinsurance syndicates;
* appoint a subagent unless the scope of the subagent's license as an insurance producer includes the kinds and classes of insurance for which the subagent is appointed;
* pay or commit the insurer to pay a claim, net of reinsurance, the amount of which exceeds one (1) percent of the insurer's policyholder's surplus as of December 31 of the last completed calendar year without the prior written approval of the insurer for the settlement and the approval is received after the insurer has been notified in writing that the claim settlement will exceed one (1) percent of the insurer's policyholder's surplus as of December 31 of the last completed calendar year;
* collect a payment from a reinsurer or commit the insurer to a claim settlement with a reinsurer without prior written approval of the insurer, but if prior written approval is given, a complete report must be forwarded to the insurer within thirty (30) days;
* permit a subagent to serve on the insurer's board of directors;
* jointly employ an individual who is employed with the insurer; or
* delegate managing general agent authority to another person.

A managing general agent must annually provide and an insurer must annually obtain a copy of certified financial statements of each managing general agent with which the insurer has done business. The financial statements must be prepared by an independent certified public accountant if the managing general agent produces or underwrites an amount of gross written premium *equal to more than five (5) percent of the policyholder's surplus in a quarter or year*, as reported in the insurer's last annual statement.

In addition to any other required loss reserve certification, if a managing general agent establishes loss reserves, the insurer must annually obtain the opinion of an independent qualified actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the managing general agent. The insurer retains an independent responsibility to determine the adequacy of its loss reserves, including those established by its managing general agents.

An insurer must at least semiannually conduct an on-site review of the underwriting and claims processing operations of the managing general agent if the managing general agent produces or underwrites an amount of gross written premium *equal to more than five (5) percent of the policyholder's surplus in a quarter or year*, as reported in the insurer's last annual statement.

An insurer must review its books and records quarterly to determine if a person or insurance producer has acted as its managing general agent. If an insurer determines that a person or insurance producer has acted as its managing general agent, the insurer must promptly notify

the person or insurance producer and the director of the determination and the insurer and person or insurance producer must fully comply with the provisions of this regulation within thirty (30) days.

An insurer may not appoint to its board of directors an officer, director, employee, subagent, insurance producer, or controlling shareholder of its managing general agent.

The actual or apparently authorized acts of the managing general agent are considered the acts of the insurer upon whose behalf it is acting.

A managing general agent may be examined by the director as if it were the insurer.

If the director determines after a hearing that a managing general agent caused loss arising out of a violation of the Insurance Code to an insurer, the director may order the managing general agent to make restitution to the insurer, the rehabilitator, or the liquidator of the insurer for the loss. Restitution ordered under this provision is in addition to any other liability of the managing general agent and does not affect the rights of a policyholder, claimant, creditor, or third party.

(e) Penalties

In addition to any other penalty provided by law, a person that the director determines has violated the provisions of the Insurance Code pertinent to insurance producers is subject to:

* a civil penalty equal to the compensation promised, paid, or to paid, directly or indirectly, to a licensee in regard to *each violation*;
* either a civil penalty of not more than *$10,000 for each violation* or a civil penalty of not more than *$25,000 for each violation if the director determines that the person willfully violated the provisions of this chapter*; and
* denial, nonrenewal, suspension, or revocation of a license.

An order issued by the director that levies a civil penalty *must specify the time period* within which the civil penalty must be fully paid. *The period may not be less than fifteen (15) days or more than one (1) year after the date of the order.*

Upon failure to pay a civil penalty when due, the director must revoke, without further hearing, all licenses of the licensee not already revoked.

(3) Third Party Administrators

A *third party administrator* is a person (individual, partnership or corporation) who performs the following administrative functions for residents of this state or residents of other states from a place of business in this state *in regard to life insurance, disability insurance or annuities*:

* claims administration and payment;
* marketing administrative functions;
* premium accounting;
* premium billing;
* coverage verification;
* underwriting authority; or
* certificate issuance.

(a) Registration Required

A person may not act as or represent to be a third-party administrator in this state or relative to a subject resident, located, or to be performed in this state, unless *registered* under this chapter or in another jurisdiction. A person may not act as or represent to be a third-party administrator representing an insurer domiciled in this state regarding a risk located outside

this state unless *registered* by this state under the provisions of this chapter.

A third-party administrator may not transact business for a kind or class of insurance for which the person is not registered.

A person who performs administrative functions, including claims administration and payment, marketing administrative functions, premium accounting, premium billing, coverage verification, underwriting authority, or certificate issuance in regard to insurance as a third-party administrator must be registered as a third-party administrator unless the person only investigates and adjusts claims and is licensed as an independent adjuster (to be discussed).

A third-party administrator may not use a fictitious name or alias unless the licensee's legal name and fictitious name or alias are on the registration.

A person who is an employee of an admitted insurer, who acts within the course and scope of that employment, and within the scope of the insurer's certificate of authority is *not required* to be registered.

A person who performs management services for an admitted insurer is *not required* to be registered as a third-party administrator if the person's compensation is not based on the volume of premium written and the person:

* is a wholly-owned subsidiary of the admitted insurer;
* wholly owns the admitted insurer;
* is a wholly-owned subsidiary of the insurance holding company that owns or controls the admitted insurer;
* is a United States manager of the United States branch of an alien admitted insurer; or
* is a manager of a group, association, pool, or organization of admitted insurers that does joint underwriting if it is subject to examination by the authorized insurance regulator in the state in which the person's principal place of business is located.

A credit union or a financial institution subject to supervision or examination by federal or state banking authorities, or a mortgage lender, that performs no functions other than advancing premiums to the insurer and collecting a debt from the insured is *not required* to be registered as a third-party administrator.

A credit card issuing company that performs no functions, including adjustment or settlement of claims, other than advancing and collecting premiums from its credit card holders who have authorized collection is *not required* to be registered as a third-party administrator.

A person who only provides services to bona fide employee benefit plans that are established by an employer or an employee organization, or both, for which the insurance laws of this state are preempted under the Employee Retirement Income Security Act of 1974, *is not required* to be additionally registered as a third-party administrator if the person certifies to the director on or before February 1 of each year its exempt status.

A third-party administrator:

* must apply for registration;
* must renew its registration; and
* is subject to hearings and orders on violations; denial, nonrenewal, suspension, or revocation of registration; penalties; and surrender of registration under the procedures set out in the Alaska Insurance Code.

(b) Qualifications

The director may not issue or renew a registration for a person, found by the director to be untrustworthy, incompetent, financially irresponsible, or who has not established to the satisfaction of the director that the person is qualified.

To qualify for issuance or renewal of a registration, an applicant or registrant must:

* be a trustworthy person;
* have active working experience in administrative functions that, in the director's opinion, exhibits the ability to competently perform the administrative functions of a third-party administrator;
* not have committed an act that is a cause for denial, nonrenewal, suspension, or revocation of a registration in this state or another jurisdiction;
* if a corporation or partnership:
- maintains a lawfully established place of business in this state, except when licensed as a nonresident;
- discloses to the director all officers, directors, or partners, and whether or not they are licensed in this state or another jurisdiction;
- designates an officer or partner responsible for the firm's compliance with the insurance statutes and regulations of this state;
* provide in or with its application:
- all basic organizational documents of the third-party administrator, including articles of incorporation, articles of association, partnership agreement, trade name certificate, trust agreement, shareholder agreement and other applicable documents and all endorsements to the required documents;
- the bylaws, rules, regulations or similar documents regulating the internal affairs of the administrator;
- the names, mailing addresses, physical addresses, official positions, and professional qualifications of persons who are responsible for the conduct of affairs of the third-party administrator; including the members of the board of directors, board of trustees, executive committee or other governing board or committee; the principal officers in the case of a corporation or the partners or members in the case of partnership or association; shareholders holding directly or indirectly ten percent (10%)more of the voting securities of the third-party administrator; and any other person who exercises control or influence over the affairs of the third-party administrator;
- certified financial statements for the prior to (2) years prepared by an independent certified public accountant that establish that the applicant is solvent, that the applicant's system of accounting, internal control, and procedure is operating effectively to provide reasonable assurance that money is promptly accounted for and paid to the person entitled to the money, and any other information that the director may require to review the current financial condition of the applicant; and
- a statement describing the business plan, including information on staffing levels and activities proposed in this state and in other jurisdictions and providing details establishing the third-party administrator's capability for providing a sufficient number of experienced and qualified personnel in the areas of claims handling, underwriting, and record keeping;
* provide to the director documents necessary to verify the statements contained in or in connection with the application; and
* notify the director within thirty (30) days in writing by certified mail of a change in principal or manager, residence, place of business, mailing address, phone number; suspension or revocation of an insurance license or registration by another state or jurisdiction; or a conviction of a misdemeanor or felony of the third-party administrator, its officers, directors, partners, owners, or employees.

The director may require that a third-party administrator maintain:

* a bond in an amount acceptable to the director and conditioned in that the third-party administrator will conduct business as required by this title; and

* an errors and omissions insurance policy acceptable to the director.

If the director finds that the applicant or registrant is qualified and that application, registration, or renewal fees have been paid, the director may issue or renew the registration.

(c) Operating Requirements for Third-Party Administrators

An insurer may not transact business with a third-party administrator unless:

* the insurer holds a certificate of authority in this state;
* the third-party administrator is registered in Alaska or, when the third-party administrator is operating only for a foreign insurer, is registered as a third-party administrator by the third-party administrator's resident insurance regulator in a state that the director has determined has enacted provisions substantially similar to those contained in the Alaska Insurance Code and that is accredited by the National Association of Insurance Commissioners;
* the third-party administrator provides the director on January 1, April 1, July 1, and October 1 of each year:
- a list of current employees, identifying those transacting business in this state or upon a subject resident, located or to be performed in this state;
- a list of current insurers under contract; and
- other information the director may require;
* a written contract is in effect between the parties that establishes the responsibilities of each party, indicates both parties' share of responsibility for a particular function, and specifies the division of responsibilities.

In addition, there must be in effect a *written contract* between the insurer and third-party administrator that contains the following provisions:

* the insurer may terminate the contract for cause upon written notice sent by certified mail to the third-party administrator and may suspend the underwriting authority of the third-party administrator during a dispute regarding the cause for termination; but the insurer must fulfill all lawful obligations with respect to policies affected by the written agreement, regardless of any dispute between the insurer and the third-party administrator;
* the third-party administrator must render accounts to the insurer detailing all transactions and remit all money due under the contract to the insurer at least monthly;
* all money collected for the account of an insurer must be held by the third-party administrator in a fiduciary account;
* the third-party administrator must comply with all applicable fiduciary account statutes and regulations;
* a fiduciary account must be used for all payments on behalf of the insurer;
* the third-party administrator may not retain more than three (3) months estimated claims payments and allocated loss adjustment expenses;
* the third-party administrator must maintain separate records for each insurer in a form usable by the insurer; the insurer or its authorized representative must have the right to audit and the right to copy all accounts and records related to the insurer's business; the director, in addition to other authority granted in this title, must have access to all books, bank accounts, and records of the third-party administrator in a form usable to the director; any trade secrets contained in books and records reviewed by the director, including the identity and addresses of policyholders and certificate holders, must be kept confidential, except that the director may use the information in a proceeding instituted against the third-party administrator or the insurer;

* the contract may not be assigned in whole or in part by the third-party administrator;
* if the contract permits the third-party administrator to do underwriting, the contract must include the following:
- the third-party administrator's maximum annual premium volume;
- the rating system and basis of the rates to be charged;
- the types of risks that may be written;
- maximum limits of liability;
- applicable exclusions;
- territorial limitations;
- policy cancellation provisions;
- the maximum policy term; and
- that the insurer must have the right to cancel or not renew a policy of insurance subject to applicable state law;
* if the contract permits the third-party administrator to administer claims on behalf of the insurer, the contract must include the following:
- written settlement authority must be provided by the insurer and may be terminated for cause upon the insurer's written notice sent by certified mail to the third-party administrator or upon the termination of the contract, but the insurer may suspend the settlement authority during a dispute regarding the cause of termination;
- claims must be reported to the insurer within thirty (30) days;
- a copy of the claim file must be sent to the insurer upon request or as soon as it becomes known that the claim has the potential to exceed an amount determined by the director or exceeds the limit set by the insurer, whichever is less, involves a coverage dispute, may exceed the third-party administrator's claims settlement authority, is open for more than six (6) months, involves extra contractual allegations, or is closed by payment in excess of an amount set by the director or an amount set by the insurer, whichever is less;
- each party to the contract must comply with unfair claims settlement statutes and regulations;
- transmission of electronic data must occur at least monthly if electronic claim files are in existence; and
- claim files must be the sole property of the insurer; upon an order of liquidation of the insurer, the third-party administrator must have reasonable access to and the right to copy the files on a timely basis; and
* the contract may not provide for commissions, fees, or charges contingent upon savings obtained in the adjustment, settlement, and payment of losses covered by the insurer's obligations; but a third-party administrator may receive performance-based compensation for providing hospital and other auditing services or may receive compensation based on premiums or charges collected or the number of claims paid or processed.

If the insurer is domiciled in this state or the third-party administrator has a place of business in this state, a copy of the contract must be filed with and approved by the director at least thirty (30) days before the third-party administrator transacts business on behalf of the insurer. If the contract is not required to be approved in advance by the director, the insurer must provide written notification to the director within thirty (30) days of the entry into or termination of a contract with a third-party administrator.

The notice must include:

- a statement of duties to be performed by the third-party administrator on behalf of the insurer;
- the kinds and classes of insurance for which the third-party administrator has authorization to act; and
- other information required by the director.

If the contract provides for the third-party administrator to receive or collect premiums, payment by or on behalf of the insured of premiums for insurance to the third-party administrator must be presumed to have been received by the insurer. Payment of return premiums or claim payments forwarded by the insurer to the third-party administrator may not be presumed to have been received by the person entitled to the money until the payments are received by the insured or claimant. Nothing in this subsection limits the rights that the insurer may have against the third-party administrator resulting from failure of the third-party administrator to make payments to persons entitled to money.

Policies, certificates, booklets, termination notices or other written communications delivered by the insurer to the third-party administrator for delivery to the insured or covered individuals must be delivered by the third-party administrator within ten (10) days after receipt of instructions from the insurer to deliver them.

When the services of a third-party administrator are utilized, the third-party administrator must provide a written notice, approved in writing by the insurer, to a covered person advising the person of the identity of the insurer and the relationship between the third-party administrator. the policyholder, and the insurer.

A third-party administrator may not:

- bind reinsurance or retrocessions on behalf of the insurer;
- commit the insurer to participate in insurance or reinsurance syndicates;
- appoint a subagent unless the scope of the subagent's license as an insurance producer includes the kinds and classes of insurance for which the subagent is appointed and there is in effect a written agency agreement that specifically sets out the duties, functions, powers, authority, and compensation of all parties to the contract;
- pay or commit the insurer to pay a claim, net of reinsurance, the amount of which exceeds one percent (1%) of the insurer's policyholder's surplus as of December 31 of the last completed calendar year *without prior written approval of the insurer* for the settlement (the approval of an insurer must be received after the insurer has been notified in writing that the claim settlement will exceed one percent (1%) of the insurer's policyholder's surplus as of December 31 of the last completed calendar year);
- collect a payment from a reinsurance or commit the insurer to a claim settlement with a reinsurer without prior written approval of the insurer, but if prior written approval is given, a complete report must be forwarded to the insurer within thirty (30) days;
- serve on the insurer's board of directors;
- jointly employ an individual who is employed by the insurer;
- delegate third-party administrator authority to another person;
- solicit applications for insurance or renewals directly through employees or by appointments of insurance producers as its subagents unless its employees of the insurance producers are licensed for the kinds or classes of insurance and the solicitation or renewals are within the scope of authority granted by the insurer contracting with the third-party administrator; or
- advertise the business underwritten by an insurer unless the advertising has been approved in writing by the insurer in advance of its use.

A third-party administrator must annually provide to the insurer and an insurer must annually obtain a copy of certified financial statements prepared by an independent certified public accountant of each third-party administrator with which the insurer has done business.

In addition to any other required loss reserve certification, if a third-party administrator establishes loss reserves, the insurer must annually obtain the opinion of an independent qualified actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the third-party administrator. The insurer retains an independent responsibility to determine the adequacy of its loss reserves, including those established by its third-party administrators.

If a third-party administrator provides services for more than 100 certificate holders on behalf of an insurer, the insurer must at least semiannually conduct a review of the operations of the third-party administrator. At last one review must be an on-site review.

A third-party administrator must maintain records as required by regulation.

An insurer may not appoint to its board of directors an officer, director, employee, subagent, insurance producer, or controlling shareholder of its third-party administrator.

An actual or apparently authorized act of the third-party administrator is considered to be the act of the insured upon whose behalf the third-party administrator is acting.

A third-party administrator may be examined by the director as if it were the insurer.

If the director determines after a hearing that a third-party administrator caused loss arising out of a violation of the Insurance Code, the director may order the third-party administrator to reimburse the insurer, the rehabilitator, or the liquidator of the insurer for the loss. Reimbursement ordered under this subsection is in addition to any other liability of the third-party administrator and does not affect the rights of a policyholder, claimant, creditor, or third-party.

(d) Penalties

In addition to any other penalty provided by law, a person that the director determines has violated the provisions of this chapter is subject to:

* a civil penalty equal to the compensation promised, paid, or to be paid directly or indirectly, to a licensee in regard to *each violation*;
* either a civil penalty of not more than *$10,000 for each violation* or a civil penalty of not more than *$25,000 for each violation if the director determines that the person willfully violated the provisions of this chapter*; and
* denial, nonrenewal, suspension or revocation of a license.

An order issued by the director that levies a civil penalty *must specify the time period* within which the penalty must be fully paid. *The period may not be less than fifteen (15) days or more than one (1) year after the date of the order.*

Upon failure to pay a civil penalty when due, the director must revoke, without further hearing, all licenses of the licensee not already revoked.

(4) Reinsurance Intermediary Broker

"Reinsurance" is insurance for insurers. Through reinsurance, one insurance company (ceding insurer) reduces its exposure by transferring (ceding) some or all of its business to another insurer (the assuming insurer).

The assuming insurer is also known as the reinsurer.

When business is reinsured on a risk by risk basis, it is called *facultative reinsurance*.

When business is reinsurance on a regular percentage basis, it is called *treaty reinsurance*.

Reinsurance allows one insurer to write a very large risk and then cede as much of the risk as

needed. Without this capacity to write larger risks, some insurers would never be able to grow.

Reinsurance is a transaction between insurance companies. The original insured is not aware of the transaction.

A *reinsurance intermediary* is a person (individual, partnership or corporation) who acts as a *producer* in:

* soliciting, negotiating or procuring the making of a reinsurance contract or binder on behalf of a *ceding* admitted insurer; or
* accepting a reinsurance contract or binder on behalf of an *assuming* admitted insurer.

A *reinsurance intermediary broker* is a person (individual, partnership or corporation) who solicits, negotiates or places reinsurance cessions or retrocessions (reinsurance of a reinsurer) on behalf of a ceding admitted insurer *without the authority to bind reinsurance on behalf of the insurer.*

(a) Qualifications

In addition to the general qualifications to qualify for issuance or renewal of a reinsurance intermediary broker license, an applicant or licensee must have at least three (3) years active working experience within the previous ten (10) calendar years in insurance administrative functions, that, in the director's opinion, exhibit the applicant's ability to competently perform the functions for all kinds and classes of insurance applied for.

The director may require that a reinsurance intermediary broker maintain:

* a bond in an amount acceptable to the director in favor of insurers and this state, and with a condition in that the reinsurance intermediary broker conduct business as required under this title; and
* an errors and omissions insurance policy acceptable to the director.

(b) Trainee Reinsurance Intermediary Brokers

An individual licensed in this state as an insurance producer, who does not have the experience required of a reinsurance intermediary broker but who otherwise meets the requirements may be employed by a licensed reinsurance intermediary broker as a *trainee reinsurance intermediary broker*, subject to the provisions of this section.

Before an individual may transact as a trainee reinsurance intermediary broker, the reinsurance intermediary broker employing the trainee reinsurance intermediary broker must submit to the director the application of the trainee reinsurance intermediary broker, with the required fee and receive the trainee reinsurance intermediary broker license.

Upon satisfying the experience requirement, a trainee reinsurance intermediary broker must apply within thirty (30) days for a reinsurance intermediary broker license.

A trainee reinsurance intermediary broker must at all times be working at the direction and under the supervision of the employing licensed reinsurance intermediary broker, and the file and record documentation must reflect the direction and supervision. Insurance activities must be in the name of the employing reinsurance intermediary broker who is responsible for all actions of the trainee reinsurance intermediary broker.

A trainee reinsurance intermediary broker is restricted to:

* assisting the employing licensed reinsurance intermediary broker in preparing applications; binders; certificates of insurance; schedules of equipment, vehicles, and drivers; loss notices to insurers, and invoices; and
* performing clerical functions for which a license is not required.

The file and record documentation must reflect compliance with this subsection.

A trainee reinsurance intermediary broker may not transact business away from the place of business with clients, insurers, or reinsurers unless a licensed reinsurance intermediary broker physically accompanies the trainee.

In addition to any other penalty provided by law:

* the director may revoke the license of a trainee reinsurance intermediary broker who the director determines has violated the provisions of this section (a licensee or other person having possession or custody of the license must immediately surrender the license to the director either personally or by certified mail);
* if the director determines that the employing reinsurance intermediary broker knew of or should have known that a trainee reinsurance intermediary broker violated this section, the employing reinsurance intermediary broker and firm, principal and manager, if any, are subject to the following penalties:

- a civil penalty equal to the compensation promised, paid, or to be paid directly or indirectly, to a licensee in regard to *each violation*;
- either a civil penalty of not more than *$10,000 for each violation* or a civil penalty of not more than *$25,000 for each violation if the director determines that the person willfully violated the provisions of this chapter*; and
- denial, nonrenewal, suspension or revocation of a license.

An order issued by the director that levies a civil penalty *must specify the time period* within which the penalty must be fully paid. *The period may not be less than fifteen (15) days or more than one (1) year after the date of the order.*

Upon failure to pay a civil penalty when due, the director must revoke, without further hearing, all licenses of the licensee not already revoked.

(c) **Operating Requirements for Reinsurance Intermediary Brokers**

An insurer may not transact business with a reinsurance intermediary broker unless:

* the insurer holds a certificate of authority in this state;
* the reinsurance intermediary broker is licensed in this state; and
* there is in effect a written contract between the parties that:

- establishes the responsibilities of each party;
- indicates each party's share of responsibility for each particular function; and
- specifies the division of responsibilities.

The written contract must be kept in the permanent records of the insurer and the reinsurance intermediary broker, be open to inspection by the director, and must contain the following minimum provisions:

* the insurer may terminate the reinsurance intermediary broker's authority at any time by written notice sent by certified mail;
* the reinsurance intermediary broker must render accounts to the insurer detailing all transactions including information necessary to support all commissions, charges, and other fees received by or owing to the reinsurance intermediary broker and remit the money due under the contract to the insurer *within thirty (30) days of receipt*;
* money collected for the account of an insurer must be held by the reinsurance intermediary broker in a fiduciary account; the reinsurance intermediary broker must comply with applicable fiduciary account statutes and regulations;
* the reinsurance intermediary broker must maintain separate accounts and records for each insurer and maintain the records in a form usable by the insurer; the insurer or the authorized representative of the insurer must have access and the right to audit and the

right to copy all accounts and records related to the insurer's business; the director, in addition to the other authority granted in this title, must have access to all books, bank accounts, and records of the reinsurance intermediary broker in a form usable to the director;

* the insurer must establish written standards for the cession or retrocession of all risks, and the reinsurance intermediary broker must comply with those standards;
* the reinsurance intermediary broker must disclose to the insurer all its relationships with insurers and reinsurers to whom risks are ceded or retroceded; and
* the contract may not be assigned in whole or in part by the reinsurance intermediary broker.

A domestic insurer may use a nonresident reinsurance intermediary broker who is not licensed under this chapter if the person is licensed in good standing as a resident reinsurance intermediary broker by an insurance regulator of another state that is accredited by the National Association of Insurance Commissioners.

Upon written request, the director may grant written permission for a domestic insurer to use an alien reinsurance intermediary broker not licensed by, and without a place of business in, a jurisdiction subject to accreditation by the National Association of Insurance Commissioners if the alien reinsurance intermediary broker is licensed in good standing by its domiciliary insurance regulator. The domestic insurer and unlicensed reinsurance intermediary broker are subject to all other requirements of this section.

An insurer may not employ a person who is employed by a reinsurance intermediary broker with which it transacts business, unless the reinsurance intermediary broker is under common control with the insurer.

A reinsurance intermediary broker must annually provide and an insurer must annually obtain a copy of certified financial statements of each reinsurance intermediary broker with which the insurer has done business, prepared by the independent certified public accountant.

If the director determines after a hearing that a reinsurance intermediary broker caused losses arising out of a violation of the Insurance Code to an insurer or reinsurer, the director may order the reinsurance intermediary broker to make restitution to the insurer, reinsurer, rehabilitator, or liquidator of the insurer or reinsurer for the net losses incurred by the insurer or reinsurer.

Restitution ordered under this subsection is in addition to any other liability of the reinsurance intermediary broker and does not affect the rights of a policyholder, claimant, creditor, or third party.

(d) **Reinsurance Intermediary Broker Records**

In addition to any other records requirements under this title, a reinsurance intermediary broker must maintain in organized form a record of each transaction including:

* the type of contract, limits, underwriting restrictions, classes of risks, and territory;
* the period of coverage, including effective and expiration dates, cancellation provisions, and required notice of cancellation;
* the reporting and settlement requirements of balances;
* the rate used to compute the reinsurance premium;
* the names and addresses of reinsurers;
* the rate of all reinsurance commissions, including the commissions on retrocessions handled by the reinsurance intermediary broker;
* the related correspondence and memoranda;
* the proof of placement;

the details regarding retrocessions handled by the reinsurance intermediary broker including the identity of retrocessionaires and the percentage of each contract assumed or ceded;

the financial records of premium and loss accounts;

if the reinsurance intermediary broker procures a reinsurance contract on behalf of an admitted ceding insurer;

written evidence directly from an assuming reinsurer that it has agreed to assume the risk; or

written evidence, if placed through a representative of the assuming reinsurer other than an employee, that the reinsurer had delegated binding authority to the representative; and

* additional information that is customary or that may be required by the director.

(e) Penalty

In addition to any other penalty provided by law, a person that the director determines has violated the provisions of this chapter is subject to:

* a civil penalty equal to the compensation promised, paid, or to be paid directly or indirectly, to a licensee in regard to *each violation*;
* either a civil penalty of not more than *$10,000 for each violation* or a civil penalty of not more than *$25,000 for each violation if the director determines that the person willfully violated the provisions of this chapter*; and
* denial, nonrenewal, suspension, or revocation of a license.

An order issued by the director that levies a civil penalty *must specify the time period* within which the civil penalty must be fully paid. *The period may not be less than fifteen (15) days or more than one (1) year after the date of the order.*

Upon failure to pay a civil penalty when due, the director must revoke, without further hearing, all licenses of the licensee not already revoked.

(5) Reinsurance Intermediary Managers

A *reinsurance intermediary manager* is a person (individual, partnership or corporation), including an insurer, who has the authority to:

* bind or manage all or part of the assumed reinsurance business of an admitted reinsurer, including the management of a separate division, department or underwriting office; and
* act as an agent for the reinsurer.

(a) Qualifications

In addition to the general qualifications to qualify for issuance or renewal of a reinsurance intermediary manager license, an applicant or licensee must have at least *three (3) years* active working experience within the previous ten (10) calendar years in insurance administrative functions, that, in the director's opinion, exhibits the applicant's abilities to competently perform the functions for all kinds and classes of insurance applied for.

The director may require that a reinsurance intermediary manager maintain:

* a surety bond in an amount acceptable to the director and with a condition that the reinsurance intermediary manager conduct business as required under this title; and
* an errors and omissions insurance policy acceptable to the director.

(b) Trainee Reinsurance Intermediary Managers

An individual licensed in this state as an insurance producer, who does not have the experience required of a reinsurance intermediary manager, but who otherwise meets the requirements, may be employed by a licensed reinsurance intermediary manager as a *trainee reinsurance intermediary manager*, subject to the provisions of this section.

Before an individual may transact as a trainee reinsurance intermediary manager, the reinsurance intermediary manager employing the trainee reinsurance intermediary manager must submit to the director the application of the trainee reinsurance intermediary manager, with the required fee and receive the trainee reinsurance intermediary manager license.

Upon satisfying the experience requirement, a trainee reinsurance intermediary manager must apply within thirty (30) days for a reinsurance intermediary manager license.

A trainee reinsurance intermediary manager must at all times be working at the direction and under the supervision of the employing licensed reinsurance intermediary manager, and the file and record documentation must reflect the direction and supervision. Insurance activities must be in the name of the employing reinsurance intermediary manager who is responsible for all actions of the trainee reinsurance intermediary manager.

A trainee reinsurance intermediary manager is restricted to:

* assisting the employing licensed reinsurance intermediary manager in preparing applications; binders; certificates of insurance; schedules of equipment, vehicles, and drivers; loss notices to insurers, and invoices; and
* performing clerical functions for which a license is not required.

The file and record documentation must reflect compliance with this subsection.

A trainee reinsurance intermediary manager may not transact business away from the place of business with clients, insurers, or reinsurers unless a licensed reinsurance intermediary manager physically accompanies the trainee.

In addition to any other penalty provided by law:

* a trainee reinsurance intermediary manager who the director determines has violated the provisions of this section must have its license revoked;
* a licensee or other person having possession or custody of the license must immediately surrender the license to the director either personally or by certified mail;
* if the director determines that the employing reinsurance intermediary manager knew of or should have known that a trainee reinsurance intermediary manager violated this section, the employing reinsurance intermediary manager and firm, principal and manager, if any, are subject to the following penalties by regulation:

- a civil penalty equal to the compensation promised, paid, or to be paid directly or indirectly, to a licensee in regard to *each violation*;
- either a civil penalty of not more than *$10,000 for each violation* or a civil penalty of not more than *$25,000 for each violation if the director determines that the person willfully violated the provisions of this chapter*; and
- denial, nonrenewal, suspension or revocation of a license.

An order issued by the director that levies a civil penalty *must specify the time period* within which the penalty must be fully paid. *The period may not be less than fifteen (15) days or more than one (1) year after the date of the order.*

Upon failure to pay a civil penalty when due, the director must revoke, without further hearing, all licenses of the licensee not already revoked.

(c) Authority of Reinsurance Intermediary Managers

A reinsurance intermediary manager has only the authority that is consistent with this title and

that is conferred by the reinsurer.

A reinsurance intermediary manager, resident or nonresident, may exercise the powers conferred by this title upon insurance producers and independent adjusters only for the kinds or classes of insurance and within the scope that reinsurance intermediary is authorized by the reinsurer appointing the reinsurance intermediary manager.

(d) Operating Requirements for Reinsurance Intermediary Managers

A reinsurer may not transact business with a reinsurance intermediary manager unless there is in effect a *written contract* approved by the reinsurer's board of directors between the parties that:

* establishes the responsibilities of each party;
* indicates each party's share of responsibility for each particular function; and
* specifies the division of responsibilities.

The contract just mentioned must include the following provisions:

* the reinsurer may terminate the contract for cause upon written notice sent by certified mail to the reinsurance intermediary manager and may suspend the underwriting authority of the reinsurance intermediary manager during a dispute regarding the cause for termination;
* the reinsurance intermediary manager must render accounts to the reinsurer detailing all transactions including information necessary to support all commissions, charges, and other fees received by or owing to the reinsurance intermediary manager and remit all money due under the contract to the insurer *at least monthly*;
* money collected for the account of a reinsurer must be held by the reinsurance intermediary manager in a fiduciary account;
* the reinsurance intermediary manager must comply with applicable fiduciary account statutes and regulations;
* the reinsurance intermediary manager must maintain a separate bank account for each reinsurer that it represents;
* a fiduciary account must be used for all payments on behalf of the reinsurer;
* the reinsurance intermediary manager may retain *not more than three (3) months* estimated claims payments and allocated loss adjustment expenses;
* the reinsurance intermediary manager must maintain separate accounts and records for each reinsurer and maintain the records in a form usable by the reinsurer; the reinsurer or its authorized representative must have access and the right to audit and the right to copy all accounts and records related to the reinsurer's business; the director, in addition to the other authority granted in this title, must have access to all books, bank accounts, and records of the reinsurance intermediary manager in a form usable to the director;
* the contract may not be assigned in whole or in part by the reinsurance intermediary manager;
* the reinsurer must establish written underwriting and rating standards for the acceptance, rejection, or cessation of all risks and the reinsurance intermediary manager must comply with the standards;
* compensation including rates, terms, purposes of commissions, charges, and other fees that the reinsurance intermediary manager may levy against the reinsurer.

If the contract permits the reinsurance intermediary manager to *settle claims* on behalf of the reinsurer:

* written settlement authority must be provided by the reinsurer and may be terminated

for cause upon the insurer's written notice by certified mail to the reinsurance intermediary manager or upon the termination of the contract; the reinsurer may suspend the settlement authority during a dispute regarding the cause of termination;

* claims must be reported to the reinsurer within thirty (30) days;
* a copy of the claim file must be sent to the reinsurer upon request or as soon as it becomes known that the claim:
  - has the potential to exceed an amount determined by the director or exceeds the limit set by the insurer, whichever is less;
  - involves a coverage dispute;
  - may exceed the reinsurance intermediary manager's claims settlement authority;
  - is open for more than six (6) months;
  - involves extra contractual allegations; or
  - is closed by payment in excess of an amount set by the director or an amount set by the insurer, whichever is less;
* the reinsurance intermediary manager must comply with unfair claims settlement statutes and regulations;
* transmission of electronic data at least once a month if electronic claims files are in existence;
* claim files must be the property of both the reinsurer and reinsurance intermediary manager, but upon an order of liquidation of the reinsurer, the files must become the sole property of the reinsurer or the reinsurer's estate; the reinsurance intermediary manager must have reasonable access to and the right to copy the files on a timely basis.

If the contract provides for *sharing of interim profits* by the reinsurance intermediary manager, the interim profits may not be paid until:

* one (1) calendar year after the end of each underwriting period for property risks and five (5) years after the end of each underwriting period for casualty risks;
* a later period established by the director for specified kinds or classes of insurance; and
* the profits have been verified.

The reinsurance intermediary manager may not:

* cede retrocessions on behalf of the reinsurer, except that the reinsurance intermediary manager may cede facultative retrocessions under obligatory agreements if the contract with the reinsurer contains reinsurance underwriting guidelines including a list of reinsurers with which automatic agreements are in effect, and, for each reinsurer, the coverage and amounts or percentages that may be reinsured, and commissions schedules;
* commit the reinsurer to participate in reinsurance syndicates;
* appoint a subagent unless the scope of the subagent's license as an insurance producer includes the kinds and classes of insurance for which the subagent is appointed;
* pay or commit the reinsurer to pay a claim, net of retrocessions, the amount of which exceeds one (1) percent of the reinsurer's policyholder's surplus as of December 31 of the last completed calendar year without the prior written approval of the reinsurer;
* collect payment from a retrocessionaire or commit the reinsurer to a claim settlement with a retrocessionaire without prior written approval of the reinsurer, but if prior written approval is given, a complete report must be forwarded to the reinsurer within thirty (30) days;

* jointly employ an individual who is employed with the reinsurer; or
* delegate reinsurance intermediary manager authority to another person.

If the insurer is domiciled in this state or the reinsurance intermediary manager has a place of business in this state, a copy of the contract must be filed with and approved by the director at least thirty (30) days before reinsurance intermediary manager transacts business on behalf of the reinsurer.

If the contract is not required to be approved in advance by the director, the insurer must provide written notification to the director within thirty (30) days of the entry into or termination of a contract with a reinsurance intermediary manager. The notice must include:

* a statement of duties to be performed by the reinsurance intermediary manager on behalf of the reinsurer;
* the kinds and classes of insurance for which the reinsurance intermediary manager has authorization to act; and
* other information required by the director.

Binding authority for all retrocession contracts or participation in reinsurance syndicates may only rest with an officer of the reinsurer who is not affiliated with a reinsurance intermediary manager.

A reinsurance intermediary manager must annually provide and a reinsurer must annually obtain a copy of certified financial statements of each reinsurance intermediary manager that the reinsurer has used, prepared by an independent certified public accountant.

The reinsurer must:

* at least semiannually conduct an on-site review of the underwriting and claims processing operations of each reinsurance intermediary manager;
* in addition to any other required loss reserve certification, annually obtain the opinion of an independent qualified actuary on business produced by the reinsurance intermediary manager if a reinsurance intermediary manager establishes loss reserves; the reinsurer retains an independent responsibility to determine the adequacy of its loss reserves, including those established by its reinsurance intermediary manager; and
* provide written notification to the director by certified mail within thirty (30) days of the termination of a contract with a reinsurance intermediary manager.

The reinsurance intermediary manager must disclose to the reinsurer a relationship with an insurer before ceding or assuming risks with the insurer under the contract.

A reinsurer may not appoint to its board of directors an officer, director, employee, subagent, insurance producer, or controlling shareholder of its reinsurance intermediary manager.

Within the scope of the actual or apparent authority, the acts of the reinsurance intermediary manager are considered the acts of the reinsurer upon whose behalf it is acting.

A reinsurance intermediary manager may be examined by the director as if it were the insurer.

If the director determines after a hearing that a reinsurance intermediary manager caused losses arising out of a violation of the Insurance Code to an insurer or reinsurer, the director may order the reinsurance intermediary manager to make restitution to the insurer, reinsurer, rehabilitator or liquidator of the insurer or reinsurer for the net losses incurred by the insurer or reinsurer. Restitution ordered under this subsection is in addition to any other liability of the reinsurance intermediary manager and does not affect the rights of a policyholder, claimant, creditor, or third party.

(e) Reinsurance Intermediary Manager Records

In addition to any other records requirements under this chapter, a reinsurance intermediary manager must maintain in organized form a complete records of each transaction including:

the type of contract, limits, underwriting restrictions, classes of risks, and territory;

the period of coverage, including effective and expiration dates, cancellation provisions, and required notice of cancellation;

disposition of outstanding reserves on covered risks;

the reporting and settlement requirements of balances;

the rate used to compute the reinsurance premium;

the names and addresses of reinsurers;

the rate of all reinsurance commissions, including the commissions on retrocessions handled by the reinsurance intermediary broker and reinsurance intermediary manager;

the related correspondence and memoranda;

the proof of placement;

the details regarding retrocessions handled by the reinsurance intermediary broker and reinsurance intermediary manager including the identity of retrocessionaires and the percentage of each contract assumed or ceded;

the financial records of premium and loss accounts; and

if the reinsurance intermediary broker procures a reinsurance contract on behalf of an admitted ceding insurer or when the reinsurance intermediary manager places a reinsurance contract on behalf of a ceding insurer, written evidence:

directly from an assuming reinsurer that it has agreed to assume the risk; or

that the reinsurer had delegated binding authority to the representative, if placed through a representative of the assuming reinsurer other than an employee of the assuming reinsurer.

(e) Penalty

In addition to any other penalty provided by law, a person that the director determines has violated the provisions of this chapter is subject to:

* a civil penalty equal to the compensation promised, paid, or to be paid directly or indirectly, to a licensee in regard to *each violation*;
* either a civil penalty of not more than *$10,000 for each violation* or a civil penalty of not more than *$25,000 for each violation if the director determines that the person willfully violated the provisions of this chapter*; and
* denial, nonrenewal, suspension, or revocation of a license.

An order issued by the director that levies a civil penalty *must specify the time period* within which the civil penalty must be fully paid. *The period may not be less than fifteen (15) days or more than one (1) year after the date of the order.*

Upon failure to pay a civil penalty when due, the director must revoke, without further hearing, all licenses of the licensee not already revoked.

(6) Surplus Lines Broker

"Surplus lines" refers to any type of insurance for which there is no ready market with the state's licensed (admitted) insurance companies. The unavailability of the market might be caused by the great dollar amount of insurance required or the loss exposure itself. Whatever the case, coverage must be placed with a non-admitted insurer.

Surplus lines insurance does *not include*:

* reinsurance;
* wet marine and transportation insurance;

* insurance independently procured;
* life insurance and annuities.

A surplus lines broker is a person (individual, partnership or corporation) licensed to place surplus lines business in Alaska.

(a) Qualifications

In addition to the general qualifications to qualify for issuance or for renewal of a surplus lines broker license, an applicant or licensee must:

* have a *minimum two (2) years active working experience within the previous five (5) calendar years as an insurance producer, managing general agent, reinsurance intermediary broker, reinsurance intermediary manager, independent adjuster, or underwriter or claims adjuster employee of an insurer* and, in the director's opinion, must exhibit the ability to competently perform the responsibilities of the license applied for;
* have and maintain while licensed, *a bond in the sum of not less than $200,000 aggregate liability* and with the conditions that the surplus lines broker conduct business under the provisions of this title, promptly remit the taxes and fees provided by law, return premiums promptly when due, and pay proper losses promptly;
* if the director requires, maintain an errors and omissions insurance policy acceptable to the director.

(b) Trainee Surplus Lines Broker

An individual licensed in this state as an insurance producer who does not have the experience required of a surplus lines broker, but who otherwise meets the requirements may be employed by a licensed surplus lines broker as a *trainee surplus lines broker*, subject to the provisions of this section.

Before an individual may transact insurance as a trainee surplus lines broker, the licensed surplus lines broker employing the trainee surplus lines broker must submit to the director the application of the trainee surplus lines broker, with the required fee and receive the trainee surplus lines broker license.

Upon satisfying the experience requirement, a trainee surplus lines broker must apply *within thirty (30) days* for a surplus lines broker license.

A trainee licensed under this section must at all times be working at the direction and under the supervision of the employing licensed surplus lines broker and the file and record documentation must reflect the direction and supervision. Insurance activities must be in the name of the employing licensed surplus lines broker who is responsible for all actions of the trainee surplus lines broker.

A trainee licensed under this section is restricted to:

* assisting the employing licensed surplus lines broker in preparing applications; binders; certificates of insurance; schedules of equipment, vehicles, and drivers; loss notices to insurers; and invoices; and
* perform clerical functions for which a license is not required.

The file and record documentation must reflect compliance with this subsection.

A trainee surplus lines broker licensed under this section may not transact business away from the place of business with clients or insurers unless a licensed surplus lines broker physically accompanies the trainee.

In addition to any other penalty provided by law:

* the director must revoke the license of a trainee surplus lines broker who the director

determines has violated the provisions of this section; a licensee or other person having possession or custody of the license must immediately surrender the license to the director either personally or by certified mail;

if the director determines that the employing surplus lines broker knew of or should have known that a trainee licensed under this section violated this section, the employing surplus lines broker and firm, principal, and manager, if any, are subject to the penalties provided by regulation.

(c) **Surplus Lines Broker Records**

In addition to any other records requirements under this chapter, a surplus lines broker must maintain in organized form a complete record including:

* the amount of insurance and perils insured;
* a complete description of property insured and the location of the property;
* gross premium charged;
* a return premium paid;
* the rate of premium charged upon the several items of property;
* the effective date of the contract and terms of the contract;
* the name and address of the insured;
* the name and address of the insurer;
* the amount of tax and other sums to be collected from the insured;
* the allocation of taxes by state;
* the identity and license number of the producing broker;
* any confirming correspondence from the insurer or the representative of the insurer; and
* the application.

(d) **Denial, Nonrenewal, Suspension, or Revocation of Surplus Lines Broker License**

In addition to other action available under this regulation, the director may deny issuance of or not renew a license, or may suspend or revoke a license of a surplus lines broker issued under this chapter for any of the following causes:

* removal of the resident surplus lines broker's office from this state;
* removal of the resident surplus lines broker's accounts and records from this state during the period within which the accounts and records are required to be maintained under this chapter;
* removal of the nonresident surplus lines broker's accounts and records required to be maintained under this chapter form the location described in the license without prior approval of the director;
* closing of the surplus lines broker's office *for a period of more than forty-five (45) calendar days*, unless permission is granted by the director;
* failure to make a required report;
* failure to transmit a required tax or fee on a surplus line premium to this state or a reciprocal state to which a tax is owing;
* failure to maintain a required bond.

(e) General Penalties

In addition to any other penalty provided by law, a person that the director determines has violated the provisions of this chapter is subject to:

* a civil penalty equal to the compensation promised, paid, or to be paid directly or indirectly, to a licensee in regard to *each violation*;
* either a civil penalty of not more than *$10,000 for each violation* or a civil penalty of not more than *$25,000 for each violation if the director determines that the person willfully violated the provisions of this chapter*; and
* denial, nonrenewal, suspension, or revocation of a license.

An order issued by the director that levies a civil penalty *must specify the time period* within which the civil penalty must be fully paid. *The period may not be less than fifteen (15) days or more than one (1) year after the date of the order.*

Upon failure to pay a civil penalty when due, the director must revoke, without further hearing, all licenses of the licensee not already revoked.

(7) Independent Adjusters

An *independent adjuster*, as the name suggests, is a person (individual, partnership or corporation) which adjusts claims arising from the insurance contracts of one or more insurers. The adjuster is an "independent" contractor, rather than an employee of the insurer(s).

(a) Qualifications

In addition to the general qualifications to qualify for issuance or renewal of an independent adjuster license, an applicant or licensee must:

* have *at least six (6) months active working experience within the previous two (2) calendar years* as either an independent adjuster trainee, an insurance producer, a managing general agent, a reinsurance intermediary broker, a reinsurance intermediary manager, a surplus lines broker, an independent adjuster, or an underwriter or claims adjuster employee of an insurer, and, in the director's opinion, exhibit the ability to competently perform the responsibilities of an independent adjuster; or
* have been previously licensed in good standing in this state as an independent adjuster *within the previous four (4) calendar years* and not have had a license suspended or revoked.

(b) Trainee Independent Adjusters

An individual resident who does not have the experience with reference to the handling of loss claims but who otherwise meets the requirements may be employed by a licensed independent adjuster as a trainee independent adjuster, subject to the provisions of this section.

Before the individual may handle loss claims, the licensed independent adjuster employing the trainee independent adjuster must submit to the director the application of the trainee independent adjuster, with the required fee and receive the trainee independent adjuster license.

The director must revoke a trainee independent adjuster license unless the individual has:

* not later than four (4) months after the effective date of the trainee adjuster license, complied with the independent adjuster licensing requirements concerning the insurance laws and regulations of this state;
* not later than eight (8) months after the effective date of the trainee adjuster license, complied with the independent adjuster licensing requirements concerning the knowledge and competence of the licensee concerning handling of loss claims and the licensee's duties and responsibilities as a licensee; and

* within twelve (12) months after the effective date of the trainee adjuster license, complied with all other independent adjuster licensing requirements.

A person whose trainee independent adjuster license was revoked for failure to meet a requirement of licensure may submit a new application for a trainee independent adjuster license after the person has successfully passed both tests required.

Upon satisfying the requirements of this section, a trainee independent adjuster must apply within thirty (30) days for an independent adjuster license.

A trainee independent adjuster must at all times be working at the direction and under the supervision of the employing licensed independent adjuster, and the file and record documentation must reflect the direction and supervision. *The employing licensed independent adjuster and its firm, manager, and principal, if any, are responsible for all insurance actions of the trainee independent adjuster.*

A trainee independent adjuster is restricted to participation in a factual investigation and a tentative closing of a loss subject to review and final determination by the employing licensed independent adjuster, and file and record documentation must reflect compliance with this.

A trainee independent adjuster may not participate in a factual investigation and a tentative closing of a loss away from the place of business unless a licensed independent adjuster physically accompanies the trainee.

In addition to any other penalty provided by law a trainee independent adjuster who the director determines has violated the provisions of this regulation will have its license terminated; a licensee or other person having possession or custody of the license must within thirty (30) days surrender the license to the director either personally or by certified mail.

(c) Insurance Producer, Managing General Agent, Reinsurance Intermediary Broker, Reinsurance Intermediary Manager, Surplus Lines Broker as Independent Adjuster

Without being required to be licensed also as an independent adjuster:

* a licensed insurance producer and a licensed managing general gent, incidental to acting as an insurance producer, may act as an adjuster and investigate, adjust, and report upon claims on behalf of and as authorized by an admitted insurer *that has appointed the insurance producer or the managing general agent as its agent*;
* a surplus lines broker may act as an adjuster and investigate, adjust, and report upon claims on behalf of and as authorized by a *nonadmitted insurer*; and
* a reinsurance intermediary broker or a reinsurance intermediary manager may act as an adjuster and investigate, adjust, and report upon claims on behalf of and as authorized *by an insurer or reinsurer under the contract required by this chapter.*

(d) Unlicensed Nonresident Adjusters

A nonresident independent adjuster not licensed by this state who is licensed by and in good standing with its resident state *may adjust:*

* *a single loss* in this state during a calendar year; or
* losses arising out of a catastrophe as declared by the director.

Within ten (10) days after the start of an investigation, the nonresident independent adjuster must advise the director in writing of the adjustment and provided the following information:

* the individual and firm name;
* the business mailing address;
* the business physical address and phone number;
* the licensing state of residence;
* the residence license number; and

* other facts that the director may require.

A nonresident independent adjuster may be sued upon a cause of action in this state arising from an adjustment under this section.

(e) **Independent Adjuster Records**

In addition to any other records requirement under this chapter, an independent adjuster must maintain in organized form a complete record of each investigation or adjustment undertaken or consummated, and a statement of the fee, commission, or other compensation received or to be received by the adjuster on account of the investigation or adjustment.

(f) **Penalties**

In addition to any other penalty provided by law, a person that the director determines has violated the provisions of this chapter is subject to:

* a civil penalty equal to the compensation promised, paid, or to be paid directly or indirectly, to a licensee in regard to *each violation*;
* either a civil penalty of not more than *$10,000 for each violation* or a civil penalty of not more than *$25,000 for each violation if the director determines that the person willfully violated the provisions of this chapter*; and
* denial, nonrenewal, suspension, or revocation of a license.

An order issued by the director that levies a civil penalty *must specify the time period* within which the civil penalty must be fully paid. *The period may not be less than fifteen (15) days or more than one (1) year after the date of the order.*

Upon failure to pay a civil penalty when due, the director must revoke, without further hearing, all licenses of the licensee not already revoked.

(8) **Firm Licenses**

"Firm" means:

* an organization of two (2) or more licensees acting in association with each other, either in a partnership, corporation, or otherwise; or
* an organization in which a single licensee has less then fifty (50) percent ownership interest in the organization.

A firm must have a firm license of the same scope as each individual employee of the firm.

~~A firm may not be licensed as an insurance producer,~~ managing general agent, reinsurance intermediary broker, reinsurance intermediary manager, surplus lines broker, or independent adjuster, ~~or transact insurance~~ *unless*:

* each individual employed as an insurance producer, managing general agent, surplus lines broker, trainee insurance producer, trainee independent adjuster, or independent adjuster by the firm is licensed as an individual of the firm; and
* the principal or manager of the firm is licensed as an individual in the firm to exercise all the powers conferred by the firm's license.

If the director determines that a firm knew or should have known of an act or representation made on the firm's behalf by a person not licensed as required by this chapter, the firm and the firm's principal or manager are subject to penalties.

In addition to any other penalty provided by law, a person that the director determines has violated the provisions of this chapter is subject to:

* a civil penalty equal to the compensation promised, paid, or to be paid directly or indirectly, to a licensee in regard to *each violation*;
* either a civil penalty of not more than *$10,000 for each violation* or a civil penalty of

not more than *$25,000 for each violation if the director determines that the person willfully violated the provisions of this chapter*; and

* denial, nonrenewal, suspension, or revocation of a license.

An order issued by the director that levies a civil penalty *must specify the time period* within which the civil penalty must be fully paid. *The period may not be less than fifteen (15) days or more than one (1) year after the date of the order.*

Upon failure to pay a civil penalty when due, the director must revoke, without further hearing, all licenses of the licensee not already revoked.

(9) Individual in the Firm Licensees

"Individual" means:

* a natural person required to be licensed *who is not acting in association with two or more licensees*, either in partnership, corporation, or otherwise; or
* an organization in which a single licensee has fifty (50) percent or more ownership interest in the organization.

"Individual in the firm" means a natural person required to be licensed who is employed by a firm.

Each individual employed as an insurance producer, managing general agent, surplus lines broker, trainee insurance producer, trainee independent adjuster, or independent adjuster by the firm is licensed as an individual in the firm.

(10) Resident

For an individual or an individual in the firm, a "resident" means a natural person:

* who is domiciled in this state;
* whose principal place of business is in this state;
* who has a present intent to remain in this state while licensed; and
* who manifests that intent by establishing an ongoing physical presence in this state.

For a firm, a "resident" means a person whose principal place of business is in this state.

(11) Nonresident Licensees

The director may license as a nonresident *licensee* a person who otherwise qualifies under this title, but who is not a resident of the state.

In addition to the other requirements of this chapter, a person may not be licensed as a nonresident licensee until the person files a *power of attorney* as follows:

* an applicant *must appoint the director* as attorney to receive service of legal process issued against the licensee in this state upon a cause of action arising in this state or relative to a subject resident, located, or to be performed in this state (Service upon the director as attorney constitutes effective legal service upon the licensee.); and
* the appointment must be irrevocable for as long as there could be a cause of action against the licensee arising out of an insurance transaction in this state or relative to a subject resident, located, or to be performed in this state.

Duplicate copies of legal process against a licensed or formerly licensed nonresident licensee must be served upon the director either by a peace officer or through certified mail with return receipt requested. At the time of service, the plaintiff must pay to the director a fee set by regulation.

Upon receiving a service of process, the director must immediately send one (1) of the copies of the process by certified mail with return receipt requested to the licensed or formerly

licensed nonresident licensee at the last address of record filed with the director.

If, under the law of another state or foreign country, a tax, license, fee, fine, penalty, deposit requirement or other material obligation, prohibition or restriction is or may be imposed upon a licensee of this state *that is in excess* of the tax, license, fee, fine, penalty, deposit requirement or other material obligation, prohibition or restriction directly imposed upon a similar licensee of another state or country under the statutes of this state, *the same tax, license, fee, fine, penalty, deposit requirement or other material obligation, prohibition or restriction may, in the discretion of the director, be imposed by the director upon the licensee of the other state or country transacting or seeking to transact business in this state.*

(12) Exceptions

A person may not act as or represent to be an insurance producer, managing general agent, reinsurance intermediary broker, reinsurance intermediary manager, surplus lines broker, or independent adjuster in this state or relative to a subject resident, located, or to be performed in this state unless licensed.

A person may not act as, or represent to be, a managing general agent, reinsurance intermediary broker, or reinsurance intermediary manager representing an insurer domiciled in this state regarding a risk located outside this state unless licensed by this state.

An insurance producer, a managing general agent, a reinsurance intermediary broker, a reinsurance intermediary manager, or a surplus lines broker may not solicit or take applications for, procure, place for others, or otherwise transact business for a kind or class of insurance for which the person is not licensed.

A person who performs the following activities for a resident of this state, or for a resident of another jurisdiction from a place in this state is *not required to be licensed as a managing general agent to perform* administrative functions, including:

* claims administration and payment;
* marketing administrative functions;
* premium accounting;
* premium billing;
* coverage verification;
* underwriting authority; or
* certificate issuance only in regard to life insurance, disability insurance, or annuities.

As noted, a managing general agent's license is not needed if the person:

* is registered as a third-party administrator; or
* only investigates and adjusts claims and is licensed as an independent adjuster.

A licensee may not use a fictitious name or alias unless the licensee's legal name and fictitious name or alias are on the license.

A person who is *an employee of an admitted insurer*, who acts within the course and scope of that employment, and within the scope of the insurer's certificate of authority *is not required to be additionally licensed.*

A person who performs management services under a written contract for an admitted insurer is not required to be licensed as a managing general agent if the person:

* is a United States manager of the United States branch of an alien admitted insurer; or
* receives compensation *not* based on the volume of premium written; and
* is a wholly-owned subsidiary of the admitted insurer;
* wholly owns the admitted insurer;

* is a wholly-owned subsidiary of the insurance holding company that owns or controls the admitted insurer.

A person who performs management services for an admitted reinsurer is not required to be licensed as a *reinsurance intermediary manager* if the person:

* receives compensation not based on the volume of premium written; and
* is a wholly-owned subsidiary of the admitted insurer;
* wholly owns the admitted insurer; or
* is a wholly-owned subsidiary of an insurance holding company that owns or controls the admitted insurer;
* is a United States manager of the United States branch of an alien admitted insurer; or
* is the manager of a group, association, pool, or organization of insurers that does joint underwriting and that is subject to examination by its resident insurance regulator in a state that:

- the director has determined has enacted provisions substantially similar to those contained in this regulation; and
- is accredited by the National Association of Insurance Commissioners.

The licensing requirement does not apply to a person licensed to practice as an attorney at law while the person is acting as an attorney at law.

A person licensed as an attorney-in-fact is not required to be additionally licensed while acting on behalf of subscribers and within the scope and authority of a subscribers agreement of a reciprocal insurer or exchange.

State licensing requirements do not apply to a person who:

* is employed on salary or hourly wage by a person licensed under this regulation solely for the performance of accounting, clerical, stenographic, and similar office duties;
* only secures and forwards information required for the purposes of group insurance covering the unpaid balance, or remaining payments proposed to be made, in connection with the purchase of merchandise or services, if the person receives no compensation, directly or indirectly, arising out of or in any way relating to the insurance transactions; or
* is employed on salary by a licensee at the licensee's place of business, is supervised by and reports directly to a licensee in the firm, and who, after explaining that the matter must be reviewed by a licensee, may:

- furnish premium estimates from published or printed lists of standard rates if the person does not advise, counsel, or suggest what coverage may be needed, or otherwise solicit insurance coverage;
- arrange appointments for a licensee if the person does not solicit insurance coverage;

* record information from an applicant or policyholder and complete for the licensee's personal review and signature, a certificate of insurance that is not a contract of insurance; the licensee's signature may be by facsimile;
* inform a policyholder of the type of coverage shown in the licensee's policy record if the person does not advise that an event or hypothetical event is or is not covered; or
* in the physical presence of the licensee, record information from an applicant or policyholder and complete for a licensee's personal review and personal signature, applications, binders, endorsements, or identification cards if the person discloses to the applicant or policyholder that the applicant or policyholder may review the matter with a licensee.

In addition to the business activities expressly exempt from licensing under this section, the

director may adopt regulations that exempt other activities from the licensing requirements of this section.

C. Companies

As previously noted, insurance companies, just as insurance agents and brokers, must be licensed to do business in Alaska. A company licensed to do business in this state is said to be "authorized" or "admitted" in Alaska. Conversely, insurers not licensed in this state are said to be "unauthorized" or "nonadmitted".

An insurer authorized to do business in Alaska receives a certificate of authority from the insurance department.

(1) Domestic

A *domestic insurer*, formed under the rules and regulations of Alaska obviously has met with the scrutiny of the state insurance department from its inception. A domestic insurer must provide the insurance department with its annual reports and comply with all state reviews and audits to maintain its license.

(2) Foreign

A *foreign insurer*, formed under the rules and regulations of a state other than Alaska must agree to comply with Alaska's insurance rules and regulations in order to obtain and maintain a license in this state. As with domestic insurers, foreign insurers must provide annual reports to the Alaska Insurance Department and submit to its audits and reviews.

Insurers violating any licensing rules in Alaska may be subject to a $2,500 fine for each violation.

D. Maintenance of Licensing

(1) License Renewal, Lapse, and Reinstatement

The director may renew a license *biennially* on a date set by the director if the licensee continues to be qualified and pays the required license fees. A licensee is responsible for knowing the date that a license lapses and for renewing a license before expiration. The director must mail a renewal notice to the licensee's current address on file with the director *thirty (30) days before the renewal date.*

If a license is not renewed on or before the renewal date set by the director, the license lapses. A licensee may not act as or represent to be an insurance producer, managing general agent, reinsurance intermediary broker, reinsurance intermediary manager, surplus lines broker, or independent adjuster during the time a license has lapsed. The director may reinstate a lapsed license if the person continues to qualify for the license, pays renewal fees, and a delayed renewal penalty.

Reinstatement does not exempt a person from a penalty provided by law for transacting business while unlicensed.

A license may not be renewed if it has lapsed for two (2) years or longer.

If a licensee does not wish to renew a license issued under this chapter, the licensee must surrender the license to the director on or before the close of business of the renewal date.

Notice of lapse from the director stating the reason for the lapse must be mailed to a licensee at the licensee's last address on record with the director. The director must obtain a certificate of mailing from the United State Postal Service.

A trainee license issued to an insurance producer or an independent adjuster is issued for a term not to exceed twelve (12) months and may not be renewed.

A *two-year trainee license* issued to a managing general agent, reinsurance intermediary broker, reinsurance intermediary manager, or surplus lines broker may be renewed *only once.*

(2) Denial, Nonrenewal, Suspension, or Revocation of Licenses

The director may deny issuance of or not renew a license, or may suspend or revoke a license for any of the following:

* a cause for which issuance of the license or its renewal could have been denied had it then existed and been known to the director;
* a violation or participation in a violation of a provision of this title;
* willful misrepresentation or fraud by the licensee or applicant to obtain or attempt to obtain a licensee;
* misappropriation, conversion to personal use, or illegally withholding money required to be held in a fiduciary capacity by a licensee or applicant;
* twisting or rebating by a licensee or applicant;
* conviction of a felony;
* the conduct of affairs under a license if the licensee exhibits conduct considered by the director to reflect incompetence or untrustworthiness, or to be a source of potential injury and loss to the public;
* the licensee or applicant dealing with, or attempting to deal with, or to exercise a power relative to, insurance outside the scope of the license of the licensee or applicant;
* failure to surrender a license as required by this chapter, or revocation of a license within the twelve (12) months preceding the date a new application is received;
* failure to pass a licensing examination;
* cheating on an examination;
* a licensee or applicant engaging in or about to engage in an unfair or fraudulent insurance transaction;
* suspension or revocation of a license in another jurisdiction;
* forgery of another's name to an application for insurance by a licensee or applicant;
* accepting insurance business from a person not licensed as required by this title if the applicant or licensee knew or should have known that the person was unlicensed.

The license of a firm and its principal or manager may be denied, nonrenewed, suspended, or revoked for a violation or cause that relates to a person representing or acting on behalf of the firm.

After a hearing, if the director determines that a person violated a provision of the licensing regulation and that the person's license should be suspended or revoked, the director must issue an order *effective ten (10) days after the date of issuing that the license is suspended or revoked.*

If the director determines the person has violated a provision of the licensing regulation, the director may place conditions on a person's license if the director finds that the conditions will protect the public from injury or potential injury.

An order suspending a license must specify the period during which the person may not seek to be licensed in this state or licensed relative to a subject resident, located, or to be performed in this state.

In addition to any other penalty provided by law, a person whose license has been suspended or revoked must pay a penalty equal to all or a portion of the compensation received during the suspension or revocation relating to the transaction of insurance.

(3) Appointment of Insurance Producer, Managing General Agent, and Reinsurance Intermediary Manager

An *appointment* must be filed with the director *at least ten (10) days before its proposed effective date* by the following licensees:

* an admitted insurer appointing a managing general agent in this state or relative to a subject resident, located, or to be performed in this state;
* a managing general agent appointing an insurance producer as its subagent in this state or relative to subjects resident, located, or to be performed in this state;
* a domestic reinsurer appointing a reinsurance intermediary manager; and
* a reinsurance intermediary manager appointing an insurance producer as its subagent in this state.

An admitted insurer appointing an insurance producer as its agent in this state or relative to a subject resident, located, or to be performed in this state must file *written notice of appointment not later than thirty (30) days from the date the written agency contract is executed* or the first insurance application is submitted to the admitted insurer by the licensed insurance producer.

If the licensed insurance producer has not received written acknowledgement of the appointment from the director within forty-five (45) days from the date the written agency is executed or the first insurance application is submitted to the admitted insurer by the insurance producer, whichever is later, the insurance producer must immediately discontinue acting as an insurance producer on behalf of the insurer until an acknowledgement has been received.

If the appointee is licensed, the director must provide written acknowledgement of the appointment, including the effective date to the person making the appointment, to the appointee, and to the insurer or reinsurer.

The person making the appointment, the appointee, and the insurer must review the acknowledgement for accuracy and advise the director of an error within thirty (30) days for correction.

An appointment *continues in force until the appointment is terminated*:

* *by the insurer, reinsurer, managing general agent as authorized by the insurer, or reinsurance intermediary manager as authorized by the reinsurer*: a written notice of termination must be mailed at least ten (10) days before the effective date of the termination to the last known address of the appointee and to the director by first class certified mail, first class registered mail, or first class with a certificate of mailing from the United States Postal Service; or
* *by the director*: a written notice of termination must be mailed at least ten (10) days before the effective date of the termination by first class certified mail to the last known address of record with the director of the appointee and insurer, reinsurer, managing general agent, or reinsurance intermediary.

A notice of termination must include a statement of the reasons for the termination. A statement of the reasons for the termination is privileged and may not be admitted as evidence in an action or proceeding against the insurer, reinsurer, managing general agent, or reinsurance intermediary or their representatives by or on behalf of a person affected by the termination, except in an action involving perjury, false statement, fraud, or failure to comply with this subsection.

The director may require that an insurer renew an appointment annually and may require payment of a renewal fee for an appointment in effect on December 31 of the current year. if the director requires that an appointment be renewed or a renewal fee be paid, the director must terminate an insurer's appointment if the renewal fees have not been received by the director on or before the close of business of March 1 of the renewal year.

4. MARKETING PRACTICES

A. Illegal Practices

Individuals are prohibited from engaging in unfair or deceptive acts or methods of competition involving the sale and servicing of insurance policies. Most prohibited acts are clearly defined in the Code; however, the Department of Insurance also may decide that other activities are deceptive or unfair.

The following practices are considered unfair methods of competition and unfair and deceptive acts concerning the business of insurance:

* misrepresentation and false advertising;
* false information;
* defamation;
* boycott, coercion and intimidation;
* false financial information;
* unlawful inducement;
* unfair discrimination;
* rebating;
* unfair claims settlement practices;
* failure to maintain complaint handling procedures.

Let's review these individually.

Misrepresentation

It is illegal for an insurer or agent to misrepresent the following:

* benefits, advantages, conditions or terms of any insurance policy;
* dividends to be received or that have been paid;
* the financial condition of any person;
* the legal reserve system on which any company operates;

or to be involved in the following:

* causing an insured to lapse, forfeit, surrender, exchange or convert a policy when not in the insured's best interest;
* getting an insured to pledge or assign a loan against an insurance policy;
* stating that an insurance policy is a share of stock;
* making a false or misleading statement as to the dividends or shares of the surplus previously paid on an insurance policy;
* using a name or title of an insurance policy or class of insurance policies misrepresenting its true nature;
* appearing to be an actual policy for a named individual when it is merely an advertisement;
* not clearly designating the name of the insurer providing the coverage or about which the statements are made; or
* being in any way misleading, false, or deceptive.

For purposes of this section, "misrepresentation" includes any statement or omission of a statement which, when taken in the context of the whole presentation, may tend to mislead or deceive the person or persons addressed.

False Advertising

Providing false information or misleading advertising is an unfair and deceptive act and a violation of insurance law.

Specifically prohibited are making, publishing, disseminating, circulating or placing before the public in a newspaper, magazine, pamphlet, TV or radio announcement, any untrue, deceptive or misleading assertion or statement about the insurance business or anyone's conduct in it.

Defamation

Defamation involves the harming of one's reputation by libel (written) or slander (oral).

Oral or written statements that are false, maliciously critical, or derogatory to the financial condition of an insurer, or intended to injure any person engaged in the insurance business are illegal.

Persons providing the director with information concerning the financial condition or practices of a license of the division are immune from liability for defamation.

Boycott, Coercion and Intimidation

It is illegal for an insurer to enter into any agreement or attempt to commit any act of boycott, coercion or intimidation that results in unreasonable restraint of trade or creates monopoly in the insurance business. This also pertains to the sale of any insurance contracts.

False Financial Statements

This prohibited practice includes:

* Intentionally circulating any false statement of fact as to the financial condition of a person.
* Knowingly making any false entry of fact in a report of the business of any person.
* Intentionally withholding or concealing documented information in the possession of any person who has received a complaint pertaining to that information.

Unlawful Inducement

"Twisting" is the practice of inducing a policyholder to lapse or cancel one policy in order to replace it with another *to the detriment of the insured.*

Unfair Discrimination

In rate setting, including payment of dividends, there must not be discrimination by an insurer;

* between individuals of the same class and equal expectation of life for life insurance;
* between individuals of the same class and hazard for disability insurance;
* on the basis of race, religion, nationality, ethnic group, age, sex, family size, occupation, place of residence or marital status.

However, an insurer may set rates in accordance with reasonable classifications based on actuarial data or actual cost experience.

A person may not practice or permit unfair discrimination against a person who provides a service covered under a group disability policy that extends coverage on an expense incurred basis, or under a group service or indemnity type contract issued by a nonprofit corporation, *if the service is within the scope of the provider's occupational license.* In this context, "provider" means:

* a state licensed physician;
* dentist;

* osteopath;
* optometrist;
* chiropractor; or
* nurse midwife.

The following acts constitute unfair discrimination between individuals of the same class *when based solely on blindness, or partial blindness*:

* refusing to insure;
* refusing to continue to insure;
* limiting the amount, extent or kind of insurance coverage available; or
* charging an individual a different rate for the same coverage.

With respect to all other conditions, including the underlying cause of the blindness or partial blindness, this section may not be interpreted to prohibit the refusal to insure, the limitation of insurance coverage, or a rate differential if that act is based on sound actuarial principles or is related to actual, demonstrated experience or to experience which can be reasonably anticipated.

For the purpose of this section, the term "refusing to insure" includes an insurer that declines to insure an individual who is blind or partially blind because the insurance policy, for which application is made, contains a provision which presumes either total, permanent, or partial disability in the event an insured person becomes blind or partially blind and would result in a valid claim under the policy.

However, an insurer may, by a policy provision, written rider or endorsement, exclude from coverage, under an insurance policy containing this type of provision, disabilities consisting solely of blindness or partial blindness *if either condition is in existence at the time the policy is issued.*

Rebating

Rebating is the return by an agent to an insured of part of the premium in order to obtain business. It can also be any inducement, favor or advantage (such as money or gifts) not specified in the policy.

Nothing of value may be given to a prospect to induce the purchase of a policy. The Code specifically describes the following as inducements to buy:

* paying or offering to pay the premium of a contract;
* giving, selling or purchasing stocks, bonds, or other securities of any insurance company, corporation, association or partnership;
* providing special favor or advantage in the dividend or other benefits received; and
* offering anything of value not specified in the contract.

However, it is *not* rebating for a company to:

* pay bonuses to nonparticipating policyholders out of surplus, provided it is in the best interests of the policyholders and the company;
* return the savings in the cost of collections to debit policyholders who have continuously made premium payments directly to the insurer's office; or
* readjust group premium rates based on the current year's loss or expense experience.

Unfair Claim Practices

The following are considered unfair claims practices:

* not responding promptly when a claim is submitted, including investigation of the

claim;

refusing to pay a claim without investigation of all available information about the claim;

not telling the insured what is going to be done about a claim within a reasonable time;

forcing insureds to sue by offering amounts much less than the amount due;

trying to settle a claim on the basis of an application which has been changed without the insured's knowledge of the change;

* paying claims to the insured or beneficiaries without a statement of the reason for payment;

telling insureds or claimants the company usually appeals arbitration awards, in order to force them to accept lower awards;

making insureds or claimants submit preliminary and final proof of loss forms, both of which are practically the same;

delaying settlement of one part of a claim in order to get the insured to take a lower settlement of another part of the claim;

not making clear to the insured or claimant why a claim was refused or a compromise offered;

misrepresenting facts or policy provisions relating to coverage of an insurance policy;

failing to adopt and implement reasonable standards for prompt investigation of claims;

failing to attempt in good faith to make prompt and equitable settlement of claims in which liability is reasonably clear;

attempting to make an unreasonably low settlement by reference to printed advertising matter accompanying or included in an application.

Penalties

If the director determines an individual of being guilty of an illegal or unfair marketing practice after a proper hearing, he/she may impose a fine of up to $2,500 for each act involved. In addition to this fine, the director may suspend or revoke the agent's or broker's license.

B. Fiduciary Responsibility

Producers are regarded as acting in a "fiduciary capacity" (one of trust) when handling premium funds.

All money, except that made payable to the insurer, representing *premium taxes and fees*, premiums or return premiums received by the licensee, must be received in the fiduciary account of the licensee and must be promptly accounted for and paid to the person entitled to the money.

For purposes of this section, the fiduciary account of the firm must be considered the fiduciary account of an individual licensee acting on behalf of the firm and *is the responsibility of the firm. Money deposited into a fiduciary account may not be commingled or otherwise combined with other money, except as allowed (to be discussed).*

In addition to any other penalty provided by law, a person who the director has determined has acted to divert or appropriate fiduciary account money for personal use will be *ordered to make restitution* and will be subject to:

* suspension or revocation of all licenses; and
* a civil penalty *not to exceed $50,000 for each violation.*

A licensee may *only* commingle *premium taxes and fees, premiums and return premiums* with additional money for the purpose of:

* advancing premiums;
* establishing reserves for the payment of return premiums; or
* establishing reserves for receiving and transmitting premium or return premium money.

Money collected for the payment of premium taxes, policy or filing fees, late payment charges, and interest from fiduciary money on deposit, may be commingled in a fiduciary account. However, such money must be separately accounted for and periodically removed from the fiduciary account.

A licensee may not treat money required to be in a fiduciary account as:

* a personal asset:
* collateral for a personal or business loan; or
* a personal asset or income on a financial statement.

However, money in a fiduciary account may be included in a financial statement of the licensee if clearly identified as fiduciary account assets and liabilities.

This section does not apply to an individual in the firm who acts solely on the behalf of a firm that maintains compliance with this section and deposits all money into the firm's fiduciary account.

Instead of maintaining a separate fiduciary account for premium trust funds, a licensed firm may apply in writing to the director for permission to maintain, while licensed or thereafter as the director may require, a deposit in a financial institution or surety bond.

A *deposit* in a financial institution or a *surety bond* must be maintained in an amount not less than 10 percent (10%) of the eligible licensee's prior year's gross written premium on insurance in this state or relative to a risk resident, located, or to be performed in this state, and in trust in favor of the director for the protection of an insurer, insured, and this state.

C. Compensation of Licensees

In order to solicit, negotiate and sell insurance, an individual must be licensed as an agent or broker. Licensed agents and brokers cannot share commissions with any unlicensed personnel nor can they delegate authority to other individuals to:

* solicit applications;
* negotiate contracts of insurance.

A licensee may not compensate or offer to compensate a person, other than an insurance producer, managing general agent, reinsurance intermediary broker, reinsurance intermediary manager, or surplus lines broker, licensed by this state who is acting within the scope of his/her license, for procuring or in any manner helping to procure applications for insurance or to place insurance in this state or relative to a risk resident, located, or to be performed in this state.

Nothing in this regulation prohibits the payment of compensation to a regular employee of an insurance producer or managing general agent by the employing licensee that is *not contingent upon the volume of business transacted.*

A licensee may not be promised or paid, directly or indirectly, compensation for procuring an application or for placing a kind or *class of insurance for which the licensee is not then licensed.*

In addition to any other penalty provided by law, the director may suspend or revoke the license of an individual licensee and a firm license participating in a violation of this section. The director may order a licensee who violates this section to pay *a penalty of not more than three (3) times the compensation promised or paid.*

D. Advertising

The Alaska Insurance Department provides guidelines for the advertising of insurance. Advertising must be free of incomplete or misleading statements concerning the insurer or policy involved.

Agents and brokers cannot represent themselves as being anything more than they are professionally. They cannot pretend to be experts in areas where they have no real certified expertise. For example, agents and brokers cannot represent themselves as insurance consultants unless they pass an insurance consultant's exam.

No person may make, publish, disseminate, circulate, or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over a radio or television station, or in any other way, *an advertisement*, announcement or statement containing an assertion, representation or statement with respect to the business of insurance or with respect to a person in the conduct of his/her insurance business, *which is untrue, deceptive or misleading.*

E. Required Records and Record Retention

Every agent and broker must keep complete records of the insurance transactions he/she performs as well as those of his/her solicitors.

A complete record of an insurance transaction should contain:

* the names of insurer and insured;
* specifics of the policy in question (policy number, inception date, expiration date, premium, etc.);
* commission disbursement;
* the names of any other licensees from whom business is accepted, and of persons to whom commissions or allowances of any kind are promised or paid;
* any other information required by the director.

Insurance records must be kept for a period of five (5) years after the completion of each transaction.

No person may make a *false entry* in a book, report or statement of a person in the insurance business, knowing it to be a false entry, or knowingly omit to make a true entry of a material fact pertaining to the business of a person in the insurance business in a book, report or statement. This is considered an illegal insurance practice punishable under the Insurance Code.

F. Controlled Business

Individuals cannot obtain insurance licenses for the sole purpose of writing business on themselves, their families or companies. This is known as "controlled business" and is seen as a method of lessening competition.

The director may not issue an insurance producer, a managing general agent, or a surplus lines broker license to a person if the director has reasonable cause to believe that the applicant would, *during the 12-month period immediately following issuance of the license, earn or receive an aggregate amount in commission, service fees, brokerage, or other valuable consideration*, directly or indirectly, *that exceeds 50 percent (50%) of the aggregate amount of compensation, commission, service fees, brokerage, or other valuable consideration* represented by all other insurance business that would be procured by or through the applicant.

In addition to any other penalty provided by law, a person that the director determines has violated the provisions of this regulation is subject to:

* a civil penalty equal to the compensation promised, paid, or to be paid, directly or

indirectly, to a licensee in regard to *each violation*;

* either a civil penalty of not more than *$10,000 for each violation* or a civil penalty of not more than *$25,000 for each violation if the director determines that the person willfully violated the provisions of this chapter*; and
* denial, nonrenewal, suspension, or revocation of a license.

An order issued by the director that levies a civil penalty *must specify the time period* within which the civil penalty must be fully paid. *The period may not be less than fifteen (15) days or more than one (1) year after the date of the order.*

Upon failure to pay a civil penalty when due, the director must revoke, without further hearing, all licenses of the licensee not already revoked.

G. Alaska Insurance Guaranty Association

The Alaska Insurance Guaranty Association was established to protect the Alaska insurance public from insolvencies of admitted insurers.

The purposes of the Alaska Insurance Guaranty Association are to:

* provide a method for the payment of claims against insolvent insurers;
* avoid unnecessary delay in the payment of covered claims;
* avoid financial loss to claimants or policyholders;
* assist in the detection and prevention of insurer insolvencies;
* provide an association of insurers who will fund the program.

The Alaska Insurance Guaranty Association covers all direct insurance written in Alaska except:

* life;
* title;
* surety;
* disability;
* credit;
* mortgage guaranty;
* ocean marine insurance.

The Insurance Guaranty Association pays covered claims except *prior* to the date a member company becomes insolvent in excess of $100 up to a maximum $300,000 (except in the case of workers' compensation which must be paid in full).

"Covered claim" means an unpaid claim, including one of unearned premiums, which arises out of and is within the coverage and not in excess of the applicable limits of an insurance policy to which the Association applies issued by an insurer, if the insurer becomes an insolvent insurer after the effective date of this chapter and:

* the claimant or insured is a resident of this state at the time of the insured event; or
* the property from which the claim arises is permanently located in this state.

"Covered claim" *does not include* any amount due a reinsurer, insurer, insurance pool, or underwriting association, as subrogation recoveries or otherwise.

For administrative purposes, the Insurance Guaranty Association is divided into three separate accounts:

* workers' compensation;
* automobile;

* all other.

H. Immunity from Reporting Fraudulent Claims

Insurers, licensed agents, brokers and other insurance personnel are deemed immune from liability when reporting fraudulent claims and/or suspicious losses to the authorities. This immunity is used to encourage individuals to cooperate with the local authorities (local prosecutors having jurisdiction over the matter at hand) for the common good.

Of course, there must be an absence of malice on the part of the individual reporting the matter.

An insurer that has reason to believe that a fraudulent claim has been made against it must send the director a report disclosing information that the director may require.

The director must investigate facts reported under this section and must refer facts indicating a violation of law to the appropriate prosecutor.

I. Premium Financing

No agent, broker or solicitor may enter into any insurance transaction in which the premium is financed by *other then the licensee* unless this arrangement is permitted by the director.

Premium finance agreements must include the following information in order to protect the insured from entering any unreasonable transaction:

* the original premium amount;
* the rate of interest for premium financing;
* the total amount of the premium that will be paid through such a transaction;
* other pertinent specific information, such as the required down payment, the number of payments to be paid and the intervals involved, etc.

A premium finance agreement may provide for the payment by the borrower of a delinquency charge for any payment that is in default *for a period of twenty (20) days or more*. The maximum amount of the charge is subject to the following limits:

* for delinquent payments of less than $250, five percent of the payment or $5, which ever is less; or
* for delinquent payments of $250 or more, two percent (2%) of the payment.

Delinquency charges need not be considered in calculating the maximum interest rate.

A licensee may not require an acceleration of payments when a delinquency occurs. Payment of the delinquent payment and delinquency charges, if any, before the effective date of the cancellation of the policy reinstates the premium finance agreement and the policy.

In the event of a default by the borrower, the licensee must give not less than 30 days' written notice to the borrower, by mail, of the licensee's intent to cancel the insurance policy. However, the licensee may give 10 days' notice of cancelation from the date of receipt of notice if the licensee can substantiate the date of notice was received by the borrower. For the purposes of this section, a signed receipt or affidavit of personal delivery is sufficient substantiation of notice.

After expiration of the notice period, the licensee, in the name of the borrower, may request cancellation of the insurance policy. The insurance policy must be cancelled as if the notice of cancellation had been submitted by the borrower but without requiring the return of the insurance policy. Upon cancelation of the policy, a notice of cancellation must be mailed by certified or registered mail to the borrower.

The only security for financed premiums must be the unearned premium or cash surrender value of the associated policy, except notes may be used to secure audit premiums which are financed after expiration of the policy or where the premium is fully earned before the policy

expiration.

A payment made as required by a premium finance agreement must be attributed only to the policy or policies financed under that agreement.

A statement fee on overdue open account premium balances as an incentive for timely payment must not exceed 1.25 percent (1.25%) per month. Licensees may charge a statement fee on unpaid premium balances up to the date premiums are remitted to the insurer. At the expiration of the time allowed to charge a statement fee, if the premium balance is still unpaid, the licensee must either:

* enter into a written premium finance agreement with the insured; or
* terminate the extension of credit.